American Physicians℠
ASSURANCE CORPORATION

Practices That Set The Standard

March 12, 2009

Sent Via Overnight Delivery Service

Michael T. McRaith
Director of Insurance
Illinois Division of Insurance
320 West Washington Street, 4th Floor
Springfield, IL 62676

Attention: Property & Casualty Section
Gayle Neuman

APA's Filing No.: IL-2009-03
NAIC No.: 33006
Company FEIN: 38-2102867

Dear Ms. Neuman:

Subject: Professional Medical Malpractice Liability
Program: ~~RATE/RULE~~ Health Care Providers Professional Liability Program
Type: **Rule Filing**
Effective Date: May 1, 2009

This is to advise that **American Physicians Assurance Corporation** wishes to place on file the below outlined revisions to its Health Care providers Professional Liability Program (HCP-PL). All changes are being disclosed via the updated manual pages, the NAIC transmittal form, and this cover letter. We are requesting an effective date of May 1, 2009.

The following items are completed and attached:
1. Rule Review Requirements Checklist.
2. NAIC Transmittal Form.
3. Illinois Certification Form for Medical Malpractice rules/rates signed by Kevin Clinton, CEO and Kevin Dyke, Chief Actuary.
4. Updated rate / rule manual pages including a final version and a highlighted version noting the changes made since the last major rate / rule filing. A copy of the Countrywide manual is also attached for reference.
7. Self-addressed stamped envelope to return a copy of the approved filing to my attention.

If you should have any questions, please contact me at 1-800-748-046, extension 6849 or e-mail me at pedgington@apcapital.com. Thank you for your assistance in this matter.

Sincerely,

Patty Edgington

Patty Edgington, AU
Compliance Manager

Enclosures

1+0
MEM
RVL

Effective March 1, 2007

Property & Casualty Transmittal Document

1. Reserved for Insurance Dept. Use Only	2. Insurance Department Use only	
	a. Date the filing is received:	
	b. Analyst:	
	c. Disposition:	
	d. Date of disposition of the filing:	
	e. Effective date of filing:	
	New Business	
	Renewal Business	
	f. State Filing #:	
	g. SERFF Filing #:	
	h. Subject Codes	

3.	Group Name	Group NAIC #
	APCapital Group, Inc.	0966

4.	Company Name(s)	Domicile	NAIC #	FEIN #	State #
	American Physicians Assurance Corp	Michigan	33006	38-2102867	

5.	Company Tracking Number	IL-2009-03

Contact Info of Filer(s) or Corporate Officer(s) [include toll-free number]

6.	Name and address	Title	Telephone #s	FAX #	e-mail
	Patty Edgington, 1301 N. Hagadorn Rd., PO Box 1471, East Lansing, MI 48826-1471	Compliance Manager	800-748-0465, ext 6849 or 517-324-6849	517-333-8232	pedgington@apcapital.com
7.	Signature of authorized filer		Patty Edgington		
8.	Please print name of authorized filer		Patty Edgington		

Filing information (see General Instructions for descriptions of these fields)

9.	**Type of Insurance (TOI)**	Medical Malpractice Claims Made 11.100			
10.	**Sub-Type of Insurance (Sub-TOI)**	Physicians and Surgeons 11.1023			
11.	**State Specific Product code(s)**(if applicable)[See State Specific Requirements]				
12.	**Company Program Title** (Marketing title)	Health Care Providers Professional Liability Program			
13.	**Filing Type**	[ ] Rate/Loss Cost [**x**] Rules [ ] Rates/Rules [ ] Forms [ ] Combination Rates/Rules/Forms [ ] Withdrawal [ ] Other (give description)			
14.	**Effective Date(s) Requested**	New:	5-1-09	Renewal:	5-1-09
15.	**Reference Filing?**	[ ] Yes [x] No			
16.	**Reference Organization** (if applicable)	N/A			
17.	**Reference Organization # & Title**				
18.	**Company's Date of Filing**	3-12-09			
19.	**Status of filing in domicile**	[ ] Not Filed [ ] Pending [x] Authorized [ ] Disapproved			

Property & Casualty Transmittal Document—

20.	**This filing transmittal is part of Company Tracking #**	IL-2009-03

21.	**Filing Description** [This area can be used in lieu of a cover letter or filing memorandum and is free-form text]

American Physicians Assurance Corporation is requesting rule changes and clarifications in conjunction with the implementation of a new computer system regarding the following items:

1. Claims made extended reporting endorsement options.
2. Corporate entity coverages and ancillary charges.

The effective date of implementation is May 1, 2009 for all new and renewal business.

22.	**Filing Fees** (Filer must provide check # and fee amount if applicable) [If a state requires you to show how you calculated your filing fees, place that calculation below]

Check #:
Amount: To be invoiced.

Refer to each state's checklist for additional state specific requirements or instructions on calculating fees.

*****Refer to the each state's checklist for additional state specific requirements (i.e. # of additional copies required, other state specific forms, etc.)**

Effective March 1, 2007

RATE/RULE FILING SCHEDULE

(This form must be provided ONLY when making a filing that includes rate-related items such as Rate; Rule; Rate & Rule; Reference; Loss Cost; Loss Cost & Rule or Rate, etc.)

(Do not refer to the body of the filing for the component/exhibit listing, unless allowed by state.)

1.	**This filing transmittal is part of Company Tracking #**	**IL-2009-03**
2.	**This filing corresponds to form filing number** (Company tracking number of form filing, if applicable)	**IL-2009-02**

☐ Rate Increase ☐ Rate Decrease ☐ Rate Neutral

3.	**Filing Method (Prior Approval, File & Use, Flex Band, etc.)**	File and Use

4a. Rate Change by Company (As Proposed)

Company Name	Overall % Indicated Change (when applicable)	Overall % Rate Impact	Written premium change for this program	# of policyholders affected for this program	Written premium for this program	Maximum % Change (where required)	Minimum % Change (where required)
American Physicians Assurance Corporation	This is not a rate change	0.0%	0	1,310	33,704,015	0.0%	0.0%

4b. Rate Change by Company (As Accepted) For State Use Only

Company Name	Overall % Indicated Change (when applicable)	Overall % Rate Impact	Written premium change for this program	# of policyholders affected for this program	Written premium for this program	Maximum % Change	Minimum % Change

5. Overall Rate Information (Complete for Multiple Company Filings only)

		COMPANY USE	STATE USE
5a	**Overall percentage rate indication (when applicable)**		
5b	**Overall percentage rate impact for this filing**		
5c	**Effect of Rate Filing – Written premium change for this program**		
5d	**Effect of Rate Filing – Number of policyholders affected**		

6.	**Overall percentage of last rate revision**	(-)1.5%
7.	**Effective Date of last rate revision**	3-1-09
8.	**Filing Method of Last filing (Prior Approval, File & Use, Flex Band, etc.)**	File and Use

9.	Rule # or Page # Submitted for Review	Replacement or withdrawn?	Previous state filing number, if required by state
01	State Exception Pages IL-1 through IL-11 are replaced with changes highlighted. The Countrywide manual is attached for reference purposes only.	[ ] New [x] Replacement [ ] Withdrawn	
02		[ ] New [ ] Replacement [ ] Withdrawn	

PC RRFS-1

ILLINOIS CERTIFICATION FOR MEDICAL MALPRACTICE RATES

(215 ILCS 5/155.18)(3) states that medical liability rates shall be certified in such filing by an officer of the company and a qualified actuary that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience.

I, R. Kevin Clinton, a duly authorized officer of American Physicians Assurance Corporation, am authorized to certify on behalf of the Company making this filing that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience, and that I am knowledgeable of the laws, regulations and bulletins applicable to the policy rates that are the subject of this filing.

I, Kevin M. Dyke, FCAS, MAAA, am authorized to certify on behalf of American Physicians Assurance Corporation, making this filing that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience, and that I am knowledgeable of the laws, regulations and bulletins applicable to the policy rates that are the subject of this filing.

R. Kevin Clinton Pres & CEO — 3-4-09

Signature and Title of Authorized Insurance Company Officer — Date

Kevin M. Dyke, FCAS, MAAA, VP & Chief Actuary — 3-4-09

Signature, Title and Designation of Authorized Actuary — Date

Insurance Company FEIN 38-2102867 Filing Number IL-2009-03

Insurer's Address 1301 N. Hagadorn Road, PO Box 1471

City East Lansing State MI Zip Code 48826-1471

Contact Person Information:

-Name and E-mail: Patty Edgington, pedgington@apcapital.com

-Direct Telephone and Fax Number: 517-324-6849 (Direct Phone) 517-333-8232 (Fax)

Neuman, Gayle

From: Edgington, Patty [pedgington@apassurance.com]
Sent: Tuesday, April 28, 2009 10:47 AM
To: Neuman, Gayle
Subject: RE: American Physicians Assurance Corp - Rate/Rule Filing #IL-2009-03

Good morning Ms. Neuman:
Here's the response to your questions.

APA gathers statistical information in-house and reports the data to the Illinois Division of Insurance in compliance with the Cost Containment Data Call for Part 4203, Subparts A. and B.

To clarify the tail issue, the overall intent is that we are changing our tail rules to offer just 1 set of limits (extension) versus 3 sets of limits (extensions) for new or renewal policies issued effective May 1, 2009 and cancelled after May 1, 2009. The reason for 3 separate paragraphs is to cover the different scenarios for policyholders with different policy dates and cancellation dates and to honor the initial offer of 3 limits to policyholders that cancelled prior to the implementation date of May 1, 2009.

Here's some examples:

Paragraph 1 is for the policyholder that has a policy effective May 2, 2009 to May 2, 2010 and submits a cancellation effective June 1, 2009, we would offer just 1 extension (one set of limits).

Paragraph 2 is for the policyholder that has a policy effective December 1, 2008 to December 1, 2009 and submits a cancellation effective June 1, 2009. We would proceed to offer the two options of either a single extension (limit) or they may initiate the 3 separate extensions (limits).

Paragraph 3 is for the policyholder that has already had his/her policy initially effective April 1, 2008 to April 1, 2009 and was cancelled effective June 1, 2008, and received the first extension last year. The policyholder would be eligible to purchase the second extension effective June 1, 2009 and next year (June 1, 2010) he would be eligible to purchase the final unlimited extension.

Please advise if you need additional information. Thank you!

Patty Edgington, AU
Compliance Manager
American Physicians Assurance Corporation
pedgington@apassurance.com
1-800-748-0465, Ext. 6849
Direct: 517-324-6849

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, April 28, 2009 9:02 AM
To: Edgington, Patty
Subject: American Physicians Assurance Corp - Rate/Rule Filing #IL-2009-03

Ms. Edgington,

We are in receipt of the above referenced filing submitted by your letter dated March 12, 2009. Please address the following concerns/issues:
1. Please indicate if your company has a plan for the gathering of statistics or the reporting of statistics to

statistical agencies? If yes, what stat agency is being used? This information is required to be submitted with each medical malpractice filing.
2. In regard to the changes to the Extended Reporting Endorsement Coverage Rule VI., Item G., please provide examples of paragraphs 2 and 3. I am not sure how they differ from paragraph 1. When you say three extensions maybe be issued, do you mean two one year extensions before the unlimited extension is issued? It seems the overuse of the term "extension" makes it unclear.
We request receipt of your response by May 5, 2009.
Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Please refer to the Property & Casualty Review Checklists before submitting any filing. The checklists can be accessed through the Division's website at idfpr.com.

FINAL DRAFT

XII. RATES, STATE RULES EXCEPTIONS – Illinois

A. Illinois Rating Territories

Territory Code	Territory Description	Territory Factor
1	Cook, Madison and St. Clair Counties	1.000
2	Jackson, Vermilion and Will Counties	0.910
3	Kane, Lake, McHenry and Winnebago Counties	0.820
4	Champaign, Macon and Sangamon Counties	0.620
5	Bureau, Coles, DeKalb, DuPage, Kankakee, LaSalle, Ogle and Randolph Counties	0.730
6	Remainder of State	0.505
7	Adams, Knox, Peoria, and Rock Island	0.470

B. Mature Claims-Made Rates - Countrywide Manual Section II. General Rules, Rule A. Rates – is amended to read: Premiums are calculated by using the mature claims-made base rates, as shown below with limits of $1,000,000/$4,000,000 and by applying applicable claims-made maturity factors or other coverage option factors.

Specialty Code	ILFs Alpha Code	Specialty Description	Terr. 1	Terr. 2	Terr. 3	Terr. 4	Terr. 5	Terr. 6	Terr. 7
229		Addictionology	18,703	17,019	15,336	11,596	13,653	9,445	8,790
230		Aerospace Medicine	24,231	22,050	19,869	15,023	17,688	12,237	11,388
254		Allergy	17,349	15,788	14,226	10,756	12,665	8,761	8,154
151		Anesthesiology	41,530	37,792	34,055	25,749	30,317	20,973	19,519
196		Anesthesiology – Pain Management	41,530	37,792	34,055	25,749	30,317	20,973	19,519
255		Cardiovascular Disease – No Surgery	28,631	26,055	23,478	17,751	20,901	14,459	13,457
281		Cardiovascular Disease - Minor Surgery	59,659	54,290	48,920	36,989	43,551	30,128	28,040
256		Dermatology	20,790	18,919	17,048	12,890	15,176	10,499	9,771
282		Dermatology – Minor Surgery	37,497	34,123	30,748	23,248	27,373	18,936	17,624
237		Diabetes – No Surgery	26,946	24,521	22,096	16,707	19,671	13,608	12,665
271		Diabetes – Minor Surgery	39,821	36,237	32,653	24,689	29,070	20,110	18,716
102	S	Emergency Medicine – No Major Surgery	99,326	90,386	81,447	61,582	72,508	50,160	46,683
238		Endocrinology – No Surgery	25,678	23,367	21,056	15,920	18,745	12,967	12,068
272		Endocrinology – Minor Surgery	37,945	34,530	31,115	23,526	27,700	19,162	17,834

Specialty Code	ILFs Alpha Code	Specialty Description	Terr. 1	Terr. 2	Terr. 3	Terr. 4	Terr. 5	Terr. 6	Terr. 7
420		Family/General Practitioners – No Surgery	34,973	31,825	28,678	21,683	25,530	17,661	16,437
421		Family/General Practitioners – Minor Surgery	46,692	42,490	38,288	28,949	34,085	23,580	21,945
521		Family/General Practitioners –Minor Surgery – 0 to 24 deliveries	47,432	43,164	38,895	29,408	34,626	23,953	22,293
240		Forensic or Legal Medicine	16,963	15,436	13,909	10,517	12,383	8,566	7,972
241		Gastroenterology – No Surgery	43,206	39,318	35,429	26,788	31,541	21,819	20,307
274		Gastroenterology – Minor Surgery	46,076	41,929	37,782	28,567	33,635	23,268	21,655
231		General Preventive Medicine – No Surgery	15,933	14,499	13,065	9,878	11,631	8,046	7,488
243		Geriatrics – No Surgery	27,381	24,917	22,452	16,976	19,988	13,827	12,869
276		Geriatrics – Minor Surgery	40,464	36,822	33,181	25,088	29,539	20,434	19,018
244		Gynecology – No Surgery	26,562	24,171	21,781	16,468	19,390	13,414	12,484
277		Gynecology – Minor Surgery	42,589	38,756	34,923	26,405	31,090	21,508	20,017
245		Hematology – No Surgery	34,973	31,825	28,678	21,683	25,530	17,661	16,437
278		Hematology – Minor Surgery	49,603	45,139	40,674	30,754	36,210	25,049	23,313
232		Hypnosis	16,562	15,072	13,581	10,269	12,090	8,364	7,784
246		Infectious Diseases – No Surgery	50,711	46,147	41,583	31,441	37,019	25,609	23,834
279		Infectious Diseases – Minor Surgery	79,933	72,739	65,545	49,558	58,351	40,366	37,568
283		Intensive Care Medicine/Hospitalist	38,772	35,283	31,793	24,039	28,304	19,580	18,223
257		Internal medicine – No Surgery	41,066	37,370	33,674	25,461	29,978	20,738	19,301
284		Internal medicine – Minor Surgery	53,464	48,652	43,840	33,148	39,029	26,999	25,128
258		Laryngology – No Surgery	19,294	17,557	15,821	11,962	14,085	9,743	9,068
285		Laryngology – Minor Surgery	43,145	39,262	35,379	26,750	31,496	21,788	20,278
801		Manipulative Medicine	17,450	15,879	14,309	10,819	12,738	8,812	8,201
471		Neonatology - No Surgery	60,567	55,116	49,665	37,552	44,214	30,586	28,466
476		Neonatology – Minor Surgery	75,710	68,896	62,082	46,940	55,268	38,234	35,584
259		Neoplastic Diseases – No Surgery	35,523	32,326	29,129	22,024	25,932	17,939	16,696
260		Nephrology – No Surgery	31,476	28,643	25,810	19,515	22,978	15,895	14,794
287		Nephrology – Minor Surgery	46,515	42,329	38,143	28,840	33,956	23,490	21,862
261		Neurology – No Surgery	42,104	38,315	34,526	26,105	30,736	21,263	19,789
288		Neurology – Minor Surgery	49,989	45,490	40,991	30,993	36,492	25,244	23,495
262		Nuclear Medicine	25,581	23,278	20,976	15,860	18,674	12,918	12,023
248		Nutrition	15,022	13,670	12,318	9,313	10,966	7,586	7,060
233		Occupational Medicine	20,192	18,375	16,557	12,519	14,740	10,197	9,490
473		Oncology – No Surgery	35,523	32,326	29,129	22,024	25,932	17,939	16,696
286		Oncology – Minor Surgery	43,745	39,808	35,871	27,122	31,934	22,091	20,560
263		Ophthalmology – No Surgery	23,763	21,624	19,485	14,733	17,347	12,000	11,168
289		Ophthalmology – Minor Surgery	25,823	23,499	21,175	16,010	18,851	13,041	12,137
264		Otology – No Surgery	19,294	17,557	15,821	11,962	14,085	9,743	9,068
290		Otology – Minor Surgery	43,145	39,262	35,379	26,750	31,496	21,788	20,278

Specialty Code	ILFs Alpha Code	Specialty Description	Terr. 1	Terr. 2	Terr. 3	Terr. 4	Terr. 5	Terr. 6	Terr. 7
265		Otorhinolaryngology – No Surgery	19,294	17,557	15,821	11,962	14,085	9,743	9,068
291		Otorhinolaryngology – Minor Surgery	43,145	39,262	35,379	26,750	31,496	21,788	20,278
266		Pathology – No Surgery	27,602	25,118	22,634	17,114	20,150	13,939	12,973
292		Pathology – Minor Surgery	48,250	43,908	39,565	29,915	35,223	24,366	22,678
267		Pediatrics – No Surgery	27,698	25,205	22,713	17,173	20,220	13,988	13,018
293		Pediatrics – Minor Surgery	41,229	37,518	33,807	25,562	30,097	20,820	19,377
234		Pharmacology	24,231	22,050	19,869	15,023	17,688	12,237	11,388
235		Physiatry or Physical Medicine and Rehabilitation	17,450	15,879	14,309	10,819	12,738	8,812	8,201
437		Physicians – No Major Surgery – acupuncture	43,745	39,808	35,871	27,122	31,934	22,091	20,560
802		Physicians – No Major Surgery – Sclerotherapy	47,672	43,382	39,091	29,557	34,801	24,075	22,406
431		Physicians – No Major Surgery – shock therapy	47,672	43,382	39,091	29,557	34,801	24,075	22,406
268		Physicians – not otherwise classified – no surgery	28,039	25,515	22,992	17,384	20,468	14,160	13,178
294		Physicians – not othewise classified – minor surgery	43,745	39,808	35,871	27,122	31,934	22,091	20,560
249		Psychiatry	19,577	17,815	16,053	12,138	14,291	9,886	9,201
250		Psychoanalysis	18,296	16,649	15,003	11,343	13,356	9,239	8,599
251		Psychosomatic Medicine	14,770	13,441	12,112	9,158	10,782	7,459	6,942
236		Public Health	16,963	15,436	13,909	10,517	12,383	8,566	7,972
269		Pulmonary Diseases – No Surgery	36,216	32,956	29,697	22,454	26,437	18,289	17,021
298		Pulmonary Diseases – Minor Surgery	61,753	56,195	50,638	38,287	45,080	31,185	29,024
253	S	Radiology – diagnostic – No Surgery	43,268	39,374	35,480	26,826	31,586	21,850	20,336
280	S	Radiology – diagnostic – Minor Surgery	65,837	59,912	53,986	40,819	48,061	33,248	30,943
425	S	Radiology – Therapeutic	48,910	44,508	40,106	30,324	35,704	24,699	22,988
252		Rheumatology – No Surgery	26,236	23,875	21,514	16,267	19,153	13,249	12,331
247		Rhinology – No Surgery	19,294	17,557	15,821	11,962	14,085	9,743	9,068
270		Rhinology – Minor Surgery	43,145	39,262	35,379	26,750	31,496	21,788	20,278
166	S	Surgery – Abdominal	99,148	90,224	81,301	61,472	72,378	50,070	46,599
101	S	Surgery – Broncho-esophagology	50,336	45,806	41,275	31,208	36,745	25,420	23,658
141	H	Surgery – Cardiac	154,358	140,466	126,573	95,702	112,681	77,951	72,548
150	H	Surgery – Cardiovascular Disease	141,068	128,372	115,676	87,462	102,979	71,239	66,302
115	S	Surgery – Colon and Rectal	66,351	60,379	54,408	41,137	48,436	33,507	31,185
472	S	Surgery – Dermatology	50,971	46,384	41,797	31,602	37,209	25,741	23,957
157	S	Surgery – Emergency Medicine	110,140	100,228	90,315	68,287	80,403	55,621	51,766
103	S	Surgery – Endocrinology	43,943	39,988	36,033	27,244	32,078	22,191	20,653
117	S	Surgery – Family/General Practice	64,564	58,754	52,943	40,030	47,132	32,605	30,345
104	S	Surgery – Gastroenterology	61,371	55,847	50,324	38,050	44,801	30,992	28,844
143	S	Surgery – General – not otherwise classified	92,067	83,781	75,495	57,081	67,209	46,494	43,271
105	S	Surgery – Geriatrics	64,705	58,881	53,058	40,117	47,234	32,676	30,411
167	H	Surgery – Gynecology	71,422	64,994	58,566	44,282	52,138	36,068	33,568
169	S	Surgery – Hand	64,413	58,616	52,819	39,936	47,021	32,529	30,274
170	S	Surgery – Head and Neck	79,367	72,224	65,081	49,207	57,938	40,080	37,302
106	S	Surgery - Laryngology	59,041	53,727	48,413	36,605	43,100	29,816	27,749

Specialty Code	ILFs Alpha Code	Specialty Description	Terr. 1	Terr. 2	Terr. 3	Terr. 4	Terr. 5	Terr. 6	Terr. 7
474	H	Surgery – Neonatology or Pediatrics	106,511	96,925	87,339	66,037	77,753	53,788	50,060
107	S	Surgery – Neoplastic	55,916	50,884	45,851	34,668	40,819	28,238	26,281
108	S	Surgery – Nephrology	59,393	54,048	48,702	36,824	43,357	29,993	27,915
152	H	Surgery – Neurology	244,420	222,422	200,424	151,540	178,426	123,432	114,877
168	H	Surgery – Obstetrics	128,387	116,832	105,277	79,600	93,722	64,835	60,342
153	H	Surgery – Obstetrics – Gynecology	128,387	116,832	105,277	79,600	93,722	64,835	60,342
560	H	Surgery – Obstetrics – Gynecology – 0 to 49 deliveries	102,715	93,471	84,226	63,683	74,982	51,871	48,276
561	H	--50 to 69 deliveries	105,919	96,386	86,853	65,670	77,321	53,489	49,782
562	H	--70 to 89 deliveries	109,127	99,306	89,484	67,659	79,663	55,109	51,290
563	H	-- 90 to 109 deliveries	115,548	105,149	94,749	71,640	84,350	58,352	54,308
564	H	--110 to 129 deliveries	121,970	110,993	100,015	75,621	89,038	61,595	57,326
565	H	--130 to 149 deliveries	128,387	116,832	105,277	79,600	93,722	64,835	60,342
566	H	--150 to 169 deliveries	141,226	128,515	115,805	87,560	103,095	71,319	66,376
567	H	--170 to 189 deliveries	154,065	140,199	126,333	95,520	112,467	77,803	72,410
568	H	--190 to 209 deliveries	166,902	151,880	136,859	103,479	121,838	84,285	78,444
569	H	--210 to 229 deliveries	179,743	163,566	147,389	111,441	131,212	90,770	84,479
570	H	--230 to 249 deliveries	192,579	175,247	157,915	119,399	140,583	97,252	90,512
571	H	--250 to 269 deliveries	205,418	186,930	168,443	127,359	149,955	103,736	96,546
572	H	--270 to 289 deliveries	218,259	198,616	178,972	135,320	159,329	110,221	102,582
573	H	--290 to more deliveries	231,095	210,297	189,498	143,279	168,700	116,703	108,615
114	S	Surgery – Ophthalmology	45,753	41,636	37,518	28,367	33,400	23,105	21,504
804	S	Surgery – Ophthalmology – Plastic	59,866	54,478	49,090	37,117	43,702	30,232	28,137
154	H	Surgery – Orthopedic	157,096	142,958	128,819	97,400	114,680	79,334	73,835
164	H	Surgery – Orthopedic – without procedures on the back	115,759	105,341	94,923	71,771	84,504	58,458	54,407
158	S	Surgery – Otology	59,041	53,727	48,413	36,605	43,100	29,816	27,749
159	S	Surgery – Otorhinolaryngology	59,041	53,727	48,413	36,605	43,100	29,816	27,749
156	H	Surgery – Plastic – not otherwise classified	94,692	86,170	77,647	58,709	69,125	47,819	44,505
155	S	Surgery – Plastic Otorhinolaryngology	89,669	81,598	73,528	55,595	65,458	45,283	42,144
160	S	Surgery – Rhinology	59,041	53,727	48,413	36,605	43,100	29,816	27,749
144	H	Surgery – Thoracic	129,202	117,574	105,946	80,105	94,318	65,247	60,725
171	H	Surgery – Traumatic	128,187	116,650	105,113	79,476	93,576	64,734	60,248
145	S	Surgery – Urological	54,013	49,152	44,290	33,488	39,429	27,276	25,386
146	H	Surgery – Vascular	146,709	133,505	120,301	90,960	107,098	74,088	68,953
120		Urology-minor	35,108	31,949	28,789	21,767	25,629	17,730	16,501
424		Urgent Care Medicine	34,973	31,825	28,678	21,683	25,530	17,661	16,437

Note: When $2,000,000/$4,000,000 Increased Limits Factor (ILF) is requested for a specialty code that displays an alpha code, either S or H, use the corresponding ILF factor as displayed in Rule F.

C. Mature Claims-Made Rates – Dentists

Specialty Code	Specialty Description	Terr. 1	Terr. 2	Terr. 3	Terr. 4	Terr. 5	Terr. 6	Terr. 7
212	Dental Surgeons – Oral or Maxillofacial – Engaged in oral surgery or operative dentistry on patients rendered unconscious through the administering of any anesthesia or analgesia	38,655	35,176	31,697	23,966	28,218	19,521	18,168
210	Dentists – Minor Surgery	19,329	17,589	15,849	11,984	14,110	9,761	9,084
211	Dentists – No Surgery - not otherwise classified	7,731	7,035	6,340	4,793	5,644	3,904	3,634

D. Mature Claims-Made Rates – Health care Facilities

1. Emergency Room Groups*

ILFs Alpha Code	Specialty Description	Terr. 1	Terr. 2	Terr. 3	Terr. 4	Terr. 5	Terr. 6	Terr. 7
S	Emergency Room Groups ("Per 100 patient visits" basis). Separate limits per member physician/health care professional may be purchased for an additional 20% charge of the "per patient visit" premium.	1,993	1,814	1,634	1,236	1,455	1,007	937

2. Urgent Care Groups*

ILFs Alpha Code	Specialty Description	Terr. 1	Terr. 2	Terr. 3	Terr. 4	Terr. 5	Terr. 6	Terr.7
	Urgent Care Groups ("Per 100 patient visits" basis). Separate limits per member physician/health care professional may be purchased for an additional 20% charge of the "per patient visit" premium.	560	510	459	347	409	283	263

3. Outpatient Surgery Centers*

ILFs Alpha Code	Specialty Description	Terr. 1	Terr. 2	Terr. 3	Terr. 4	Terr. 5	Terr. 6	Terr.7
S	Outpatient Surgery Centers (Surgicenters) ("Per 100 patient visits" basis). All physicians must be separately insured by American Physicians in order to provide coverage for the outpatient surgery center.	2,833	2,578	2,323	1,756	2,068	1,431	1,331

4. Additional Health care Facility Rates (per $1000 receipts basis)*

ILFs Alpha Code	X-Ray / Imaging Laboratory/Code 88526	Terr. 1	Terr.2	Terr.3	Terr.4	Terr 5	Terr5	Terr 7
		7.43	7.43	7.43	7.43	7.43	7.43	7.43

E. Premium Charges for Vicarious, Shared and Separate Limits
Under Countrywide Rule IX., Item D., Premium Charges for Vicarious, Shared and Separate Limits is replaced in its entirety with the following:

Specialty Code	Health care Professional	Vicarious Limit Charge	Shared Limit Charge (based upon retroactive date of Named Insured)	Separate Limit Charge (based upon retroactive date of Health care Professional)
411	Chiropractor	0%	10% of class 420	20% of class 420
452	Nurse Anesthetist	0%	3% of class 151	6% of class 151
962	Nurse Midwife	0%	10% of class 153	20% of class 153
963	Nurse Practitioner	0%	3% of class 420	6% of class 420
942	Perfusionist	0%	3% of class 420	6% of class 420
807	Physician Assistant	0%	3% of class 420	6% of class 420
943	Podiatrist/incl. surg.	0%	21% of class 143	42% of class 143
944	Podiatrist – no surg.	0%	33% of class 420	66% of class 420
946	Psychologist	0%	3% of class 249	6% of class 249
808	Surgeon Assistant	0%	3% of class 420	6% of class 420

F. Higher limits of liability may be purchased at premiums derived by applying the following factors to the $1,000,000/$4,000,000 rates:

Higher Limits of Liability	All Other Physicians and Dentists	Emergency Medicine, Radiologists, All Other Surgery **(S)**	Selected Surgical Specialties **(H)**
$2,000,000/$4,000,000	1.344	1.418	1.460

For higher Limits of Liability – Refer to Company

G. Limits that are less than these $1,000,000/$4,000,000 may be purchased at premiums derived from applying the following decreased limit factors to the $1,000,000/$4,000,000 rates (not including any credit applied for a deductible):

Limits of Liability	All Physicians, Surgeons, and Dentists
$100,000/$400,000	0.480
$200/000/$800,000	0.620
$250,000/$1,000,000	0.665
$300,000/$1,200,000	0.700
$500,000/$2,000,000	0.790
$750,000/$3,000,000	0.920
$1,000,000/$2,000,000	0.980
$1,000,000/$4,000.000	1.000

H. Claims-Made Maturity Factors

Note: If the retroactive date falls on a date other than the anniversary date, a factor will be used that is pro-rating the two applicable maturity factors. These factors are applied to the mature claims-made base rates.

First Year	0.25
Second Year	0.40
Third Year	0.75
Fourth Year	0.90
Fifth Year	0.95
Sixth Year	0.98
Mature	1.00

I. Under Countrywide Claims Made Extended Reporting Endorsement Coverage Rule VI., Item G. is deleted in its entirety and replaced with the following:
Claims Made Extended Reporting Endorsement Rule
Claims-made reporting period extension(s) ("tail" coverage) are offered (unless coverage is automatically provided within the terms of the policy) to any insured whose coverage is terminated for any reason.

1. Tail provision #1 – For new or renewal policies effective May 1, 2009 and after and cancelled effective after May 1, 2009, the following option will apply:
   a. A single extension for an unlimited reporting period may be purchased. One set of limits of liability is provided for the entire unlimited reporting period. The rates for this extension are computed by applying the applicable reporting period extension factor displayed in Item J. shown below to the annual expiring premium. A suspension of coverage discount will not be included in the determination of the annual expiring premium. Payment is due in one lump sum or payments may be spread equally over three annual installments. No installment charge will apply.

2. Tail provision #2 – For new or renewal policies effective prior to May 1, 2009 and cancelled effective May 1, 2009 and after, the following two options apply:
   a. A single extension for an unlimited reporting period may be purchased. One set of limits of liability is provided for the entire unlimited reporting period. The rates for this extension are computed by applying the applicable reporting period extension factor displayed in Item J. shown below to the annual expiring premium. A suspension of coverage discount will not be included in the determination of the annual expiring premium.
   b. Alternatively, three extensions may be issued. One as of the policy termination date and the subsequent two anniversaries of the termination date. Separate limits apply for each of the three extensions. The final extension is an unlimited extension. Premiums for each extension are 33.3% of the rate applicable to the single unlimited extension. A suspension of coverage discount will not be included in the determination of the annual expiring premium.

3. Tail provision #3 – For policies already cancelled effective May 1, 2009 and prior, the following option will apply:
   a. The remaining extension(s) of the three extensions option may be purchased as of the policy termination date and the anniversary (ies) of the termination. Separate limits apply for each of the extension(s). The final extension is an unlimited extension. Premiums for each extension are 33.3% of the rate applicable to the single extension.

J. Factors are applied to the claims-made rate applicable to the annual expiring policy at the time the extended reporting endorsement is offered.

First Year	4.00
Second Year	3.88
Third Year	2.40
Fourth Year	2.11
Fifth Year	2.05
Sixth Year	2.01
Mature	1.97

K. Corporate Entity Coverage

Under Countrywide Corporate Entity Coverage Rule, Item A. is deleted in its entirety and replaced with the following:

A. Organization Coverage – Shared Limits (Non-Stacking)
A professional association, corporation or other similar professional legal entity will be the named insured with no additional limits of insurance applicable to the organization. Physicians and eligible health care professionals will be scheduled on the same policy with a separate limit of liability.

Reporting extension coverage (tail) will be offered to the physicians and eligible health care professionals according to rules stated in these exception pages. A reporting extension coverage (tail) will be given to the organization if at least one physician purchases their tail. In the event no physicians purchase their tail, the corporate entity will have no tail coverage. An option to purchase the corporate tail coverage will be offered at 20% of the member's tail premiums.

Under Countrywide Corporate Entity Coverage Rule, Item B. Organization Coverage Charge – Separate Limits (Stacking), sub item 3. is replaced with the following:

3.

# of Insureds	Charge
2-5	15.0%
6-9	12.0%
10-19	9.0%
20 or more	7.0%

L. Part-Time Rule

Under Countrywide Rule VI. Special Rating Rules, Item A. Part Time is replaced with the following:

A. Part Time: 60% of the otherwise applicable rate applies to physicians (see eligibility requirements under General Rules) with American Physicians insured exposure averaging 20 hours or less per week. If evidence of insurance is provided for any professional liability exposure insured by any other carrier, that other exposure would be excluded from the American Physicians policy. Other credits may be reduced due to lower premiums with this rating.

XIII. Merit Rating

In order to be eligible for any merit-rating plan, the incurred loss ratio over the last 10 years shall not exceed **135%**. The total credit that may be applied under the Claims-Free Credit Rule is **-15%** and the total credit/debit that may be applied under the Schedule Rating Plan is **+/- 35%.**

A. Claim-Free Credit

See countrywide manual Section X. Merit Rating, Rule A. for the underwriting criteria.
Rule 1. is deleted in its entirety and replaced with the following. 1. The company will allow a credit to those applicants and insureds who have maintained a practice without substantial change for at least the immediately prior three years and who have incurred no claims for the immediately prior three or more years. A claim resulting in cumulative expense payments up to $10,000 will not count as a claim.

Below is the Claim-Free Credit Schedule for use in Illinois:

1. Credit Schedule:

Years of Claims-Free Experience	Credit
Three to Five Years	5%
Six to Seven Years	10%
Eight or More Years	15%

B. Schedule Rating Plan

The premium may be credited or debited based on the total of credits and debits derived from the following "risk characteristics" schedule. The maximum allowable credit/debit for the Schedule Rating Plan is **+/- 35%.**

	Maximum Credit	Maximum Debit
1. Professional Skills, Quality of Care Use of a recognized system of clinical guidelines. Relevant board certification. Accreditation status by a recognized regulatory body. The provision of medical care limited to qualified individuals. Continuing education of all professional staff beyond what is required by state licensing regulation. Maintenance of premises and equipment.	10%	10%
2. Patient Rapport Length of service and reputation in community. Established policies and procedures for patient services. Cooperation with the Company claims management and resolution procedures.	10%	10%
3. Record Keeping A well-maintained patient record system in place: thorough documentation of patient care and interaction; follow-up system for diagnostic studies, consultation and appointments.	10%	10%
4. Risk Characteristics	5%	5%
a. Documented successful completion of an approved office risk analysis/communication skills assessment/risk management on-site visit and/or education program, including an appropriate response to recommendations made.		
b. Documented attendance at an approved risk management seminar, or successful completion of an approved risk management correspondence course.		

XIV. Quarterly Installment Option and Monthly Installment Option

American Physicians offers the following: (does not apply to Claims-Made Reporting Period Extensions ("tail coverage").

4-pay (quarterly)	25% down payment	3 equal installments (Due 4th, 7th, and 10th months).
9-pay (monthly)	15% down payment	8 equal installments (Due 2nd, 3rd, 4th, 5th, 6th, 7th, 8th, and 9th months).

- A $10 installment fee will be applied to all payment plans/per installment. No interest will be charged.

XV. Deductibles

See Countrywide Manual, Section V. for underwriting criteria.
Item C. from the Deductible section in the Countrywide Manual is deleted and replaced with the following: Deductible factors are applied to the $1,000,000/$4,000,000 base rate, Section IV, Rating Steps, Item D to derive the deductible credit amount.

Deductible Amount Per Incident	Indemnity Only Factor	Indemnity and Defense Factor
$5,000	.01	.03
$10,000	.03	.05
$15,000	.04	.08
$25,000	.07	.12
$30,000	.08	.13
$50,000	.12	.19
$75,000	.16	.25
$100,000	.19	.30
$200,000	.27	.43

XVI. Risk Management Activities Discounts

See Section XIII. Merit Rating, Rule B., Schedule Rating Plan, sub item 4 – Risk Characteristics on page IL-9 for the Underwriting Criteria.

XVII. Consent to Rate

Under Countrywide Rules, Rule XI. Consent to Rate is deleted in its entirety.

XVIII. Individual Risk

Individual rating may be done for specific risks that have unique hazards and unique expenses. subject to underwriting approval.

XII. RATES, STATE RULES EXCEPTIONS – Illinois HIGHLIGHTED VERSION

A. Illinois Rating Territories

Territory Code	Territory Description	Territory Factor
1	Cook, Madison and St. Clair Counties	1.000
2	Jackson, Vermilion and Will Counties	0.910
3	Kane, Lake, McHenry and Winnebago Counties	0.820
4	Champaign, Macon and Sangamon Counties	0.620
5	Bureau, Coles, DeKalb, DuPage, Kankakee, LaSalle, Ogle and Randolph Counties	0.730
6	Remainder of State	0.505
7	Adams, Knox, Peoria, and Rock Island	0.470

B. Mature Claims-Made Rates - Countrywide Manual Section II. General Rules, Rule A. Rates – is amended to read: Premiums are calculated by using the mature claims-made base rates, as shown below with limits of $1,000,000/$4,000,000 and by applying applicable claims-made maturity factors or other coverage option factors.

Specialty Code	ILFs Alpha Code	Specialty Description	Terr. 1	Terr. 2	Terr. 3	Terr. 4	Terr. 5	Terr. 6	Terr. 7
229		Addictionology	18,703	17,019	15,336	11,596	13,653	9,445	8,790
230		Aerospace Medicine	24,231	22,050	19,869	15,023	17,688	12,237	11,388
254		Allergy	17,349	15,788	14,226	10,756	12,665	8,761	8,154
151		Anesthesiology	41,530	37,792	34,055	25,749	30,317	20,973	19,519
196		Anesthesiology – Pain Management	41,530	37,792	34,055	25,749	30,317	20,973	19,519
255		Cardiovascular Disease – No Surgery	28,631	26,055	23,478	17,751	20,901	14,459	13,457
281		Cardiovascular Disease - Minor Surgery	59,659	54,290	48,920	36,989	43,551	30,128	28,040
256		Dermatology	20,790	18,919	17,048	12,890	15,176	10,499	9,771
282		Dermatology – Minor Surgery	37,497	34,123	30,748	23,248	27,373	18,936	17,624
237		Diabetes – No Surgery	26,946	24,521	22,096	16,707	19,671	13,608	12,665
271		Diabetes – Minor Surgery	39,821	36,237	32,653	24,689	29,070	20,110	18,716
102	S	Emergency Medicine – No Major Surgery	99,326	90,386	81,447	61,582	72,508	50,160	46,683
238		Endocrinology – No Surgery	25,678	23,367	21,056	15,920	18,745	12,967	12,068
272		Endocrinology – Minor Surgery	37,945	34,530	31,115	23,526	27,700	19,162	17,834

Specialty Code	ILFs Alpha Code	Specialty Description	Terr. 1	Terr. 2	Terr. 3	Terr. 4	Terr. 5	Terr. 6	Terr. 7
420		Family/General Practitioners – No Surgery	34,973	31,825	28,678	21,683	25,530	17,661	16,437
421		Family/General Practitioners – Minor Surgery	46,692	42,490	38,288	28,949	34,085	23,580	21,945
521		Family/General Practitioners –Minor Surgery – 0 to 24 deliveries	47,432	43,164	38,895	29,408	34,626	23,953	22,293
240		Forensic or Legal Medicine	16,963	15,436	13,909	10,517	12,383	8,566	7,972
241		Gastroenterology – No Surgery	43,206	39,318	35,429	26,788	31,541	21,819	20,307
274		Gastroenterology – Minor Surgery	46,076	41,929	37,782	28,567	33,635	23,268	21,655
231		General Preventive Medicine – No Surgery	15,933	14,499	13,065	9,878	11,631	8,046	7,488
243		Geriatrics – No Surgery	27,381	24,917	22,452	16,976	19,988	13,827	12,869
276		Geriatrics – Minor Surgery	40,464	36,822	33,181	25,088	29,539	20,434	19,018
244		Gynecology – No Surgery	26,562	24,171	21,781	16,468	19,390	13,414	12,484
277		Gynecology – Minor Surgery	42,589	38,756	34,923	26,405	31,090	21,508	20,017
245		Hematology – No Surgery	34,973	31,825	28,678	21,683	25,530	17,661	16,437
278		Hematology – Minor Surgery	49,603	45,139	40,674	30,754	36,210	25,049	23,313
232		Hypnosis	16,562	15,072	13,581	10,269	12,090	8,364	7,784
246		Infectious Diseases – No Surgery	50,711	46,147	41,583	31,441	37,019	25,609	23,834
279		Infectious Diseases – Minor Surgery	79,933	72,739	65,545	49,558	58,351	40,366	37,568
283		Intensive Care Medicine/Hospitalist	38,772	35,283	31,793	24,039	28,304	19,580	18,223
257		Internal medicine – No Surgery	41,066	37,370	33,674	25,461	29,978	20,738	19,301
284		Internal medicine – Minor Surgery	53,464	48,652	43,840	33,148	39,029	26,999	25,128
258		Laryngology – No Surgery	19,294	17,557	15,821	11,962	14,085	9,743	9,068
285		Laryngology – Minor Surgery	43,145	39,262	35,379	26,750	31,496	21,788	20,278
801		Manipulative Medicine	17,450	15,879	14,309	10,819	12,738	8,812	8,201
471		Neonatology - No Surgery	60,567	55,116	49,665	37,552	44,214	30,586	28,466
476		Neonatology – Minor Surgery	75,710	68,896	62,082	46,940	55,268	38,234	35,584
259		Neoplastic Diseases – No Surgery	35,523	32,326	29,129	22,024	25,932	17,939	16,696
260		Nephrology – No Surgery	31,476	28,643	25,810	19,515	22,978	15,895	14,794
287		Nephrology – Minor Surgery	46,515	42,329	38,143	28,840	33,956	23,490	21,862
261		Neurology – No Surgery	42,104	38,315	34,526	26,105	30,736	21,263	19,789
288		Neurology – Minor Surgery	49,989	45,490	40,991	30,993	36,492	25,244	23,495
262		Nuclear Medicine	25,581	23,278	20,976	15,860	18,674	12,918	12,023
248		Nutrition	15,022	13,670	12,318	9,313	10,966	7,586	7,060
233		Occupational Medicine	20,192	18,375	16,557	12,519	14,740	10,197	9,490
473		Oncology – No Surgery	35,523	32,326	29,129	22,024	25,932	17,939	16,696
286		Oncology – Minor Surgery	43,745	39,808	35,871	27,122	31,934	22,091	20,560
263		Ophthalmology – No Surgery	23,763	21,624	19,485	14,733	17,347	12,000	11,168
289		Ophthalmology – Minor Surgery	25,823	23,499	21,175	16,010	18,851	13,041	12,137
264		Otology – No Surgery	19,294	17,557	15,821	11,962	14,085	9,743	9,068
290		Otology – Minor Surgery	43,145	39,262	35,379	26,750	31,496	21,788	20,278

Specialty Code	ILFs Alpha Code	Specialty Description	Terr. 1	Terr. 2	Terr. 3	Terr. 4	Terr. 5	Terr. 6	Terr. 7
265		Otorhinolaryngology – No Surgery	19,294	17,557	15,821	11,962	14,085	9,743	9,068
291		Otorhinolaryngology – Minor Surgery	43,145	39,262	35,379	26,750	31,496	21,788	20,278
266		Pathology – No Surgery	27,602	25,118	22,634	17,114	20,150	13,939	12,973
292		Pathology – Minor Surgery	48,250	43,908	39,565	29,915	35,223	24,366	22,678
267		Pediatrics – No Surgery	27,698	25,205	22,713	17,173	20,220	13,988	13,018
293		Pediatrics – Minor Surgery	41,229	37,518	33,807	25,562	30,097	20,820	19,377
234		Pharmacology	24,231	22,050	19,869	15,023	17,688	12,237	11,388
235		Physiatry or Physical Medicine and Rehabilitation	17,450	15,879	14,309	10,819	12,738	8,812	8,201
437		Physicians – No Major Surgery – acupuncture	43,745	39,808	35,871	27,122	31,934	22,091	20,560
802		Physicians – No Major Surgery – Sclerotherapy	47,672	43,382	39,091	29,557	34,801	24,075	22,406
431		Physicians – No Major Surgery – shock therapy	47,672	43,382	39,091	29,557	34,801	24,075	22,406
268		Physicians – not otherwise classified – no surgery	28,039	25,515	22,992	17,384	20,468	14,160	13,178
294		Physicians – not othewise classified – minor surgery	43,745	39,808	35,871	27,122	31,934	22,091	20,560
249		Psychiatry	19,577	17,815	16,053	12,138	14,291	9,886	9,201
250		Psychoanalysis	18,296	16,649	15,003	11,343	13,356	9,239	8,599
251		Psychosomatic Medicine	14,770	13,441	12,112	9,158	10,782	7,459	6,942
236		Public Health	16,963	15,436	13,909	10,517	12,383	8,566	7,972
269		Pulmonary Diseases – No Surgery	36,216	32,956	29,697	22,454	26,437	18,289	17,021
298		Pulmonary Diseases – Minor Surgery	61,753	56,195	50,638	38,287	45,080	31,185	29,024
253	S	Radiology – diagnostic – No Surgery	43,268	39,374	35,480	26,826	31,586	21,850	20,336
280	S	Radiology – diagnostic – Minor Surgery	65,837	59,912	53,986	40,819	48,061	33,248	30,943
425	S	Radiology – Therapeutic	48,910	44,508	40,106	30,324	35,704	24,699	22,988
252		Rheumatology – No Surgery	26,236	23,875	21,514	16,267	19,153	13,249	12,331
247		Rhinology – No Surgery	19,294	17,557	15,821	11,962	14,085	9,743	9,068
270		Rhinology – Minor Surgery	43,145	39,262	35,379	26,750	31,496	21,788	20,278
166	S	Surgery – Abdominal	99,148	90,224	81,301	61,472	72,378	50,070	46,599
101	S	Surgery – Broncho-esophagology	50,336	45,806	41,275	31,208	36,745	25,420	23,658
141	H	Surgery – Cardiac	154,358	140,466	126,573	95,702	112,681	77,951	72,548
150	H	Surgery – Cardiovascular Disease	141,068	128,372	115,676	87,462	102,979	71,239	66,302
115	S	Surgery – Colon and Rectal	66,351	60,379	54,408	41,137	48,436	33,507	31,185
472	S	Surgery – Dermatology	50,971	46,384	41,797	31,602	37,209	25,741	23,957
157	S	Surgery – Emergency Medicine	110,140	100,228	90,315	68,287	80,403	55,621	51,766
103	S	Surgery – Endocrinology	43,943	39,988	36,033	27,244	32,078	22,191	20,653
117	S	Surgery – Family/General Practice	64,564	58,754	52,943	40,030	47,132	32,605	30,345
104	S	Surgery – Gastroenterology	61,371	55,847	50,324	38,050	44,801	30,992	28,844
143	S	Surgery – General – not otherwise classified	92,067	83,781	75,495	57,081	67,209	46,494	43,271
105	S	Surgery – Geriatrics	64,705	58,881	53,058	40,117	47,234	32,676	30,411
167	H	Surgery – Gynecology	71,422	64,994	58,566	44,282	52,138	36,068	33,568
169	S	Surgery – Hand	64,413	58,616	52,819	39,936	47,021	32,529	30,274
170	S	Surgery – Head and Neck	79,367	72,224	65,081	49,207	57,938	40,080	37,302
106	S	Surgery - Laryngology	59,041	53,727	48,413	36,605	43,100	29,816	27,749

Specialty Code	ILFs Alpha Code	Specialty Description	Terr. 1	Terr. 2	Terr. 3	Terr. 4	Terr. 5	Terr. 6	Terr. 7
474	H	Surgery – Neonatology or Pediatrics	106,511	96,925	87,339	66,037	77,753	53,788	50,060
107	S	Surgery – Neoplastic	55,916	50,884	45,851	34,668	40,819	28,238	26,281
108	S	Surgery – Nephrology	59,393	54,048	48,702	36,824	43,357	29,993	27,915
152	H	Surgery – Neurology	244,420	222,422	200,424	151,540	178,426	123,432	114,877
168	H	Surgery – Obstetrics	128,387	116,832	105,277	79,600	93,722	64,835	60,342
153	H	Surgery – Obstetrics – Gynecology	128,387	116,832	105,277	79,600	93,722	64,835	60,342
560	H	Surgery – Obstetrics – Gynecology – 0 to 49 deliveries	102,715	93,471	84,226	63,683	74,982	51,871	48,276
561	H	--50 to 69 deliveries	105,919	96,386	86,853	65,670	77,321	53,489	49,782
562	H	--70 to 89 deliveries	109,127	99,306	89,484	67,659	79,663	55,109	51,290
563	H	-- 90 to 109 deliveries	115,548	105,149	94,749	71,640	84,350	58,352	54,308
564	H	--110 to 129 deliveries	121,970	110,993	100,015	75,621	89,038	61,595	57,326
565	H	--130 to 149 deliveries	128,387	116,832	105,277	79,600	93,722	64,835	60,342
566	H	--150 to 169 deliveries	141,226	128,515	115,805	87,560	103,095	71,319	66,376
567	H	--170 to 189 deliveries	154,065	140,199	126,333	95,520	112,467	77,803	72,410
568	H	--190 to 209 deliveries	166,902	151,880	136,859	103,479	121,838	84,285	78,444
569	H	--210 to 229 deliveries	179,743	163,566	147,389	111,441	131,212	90,770	84,479
570	H	--230 to 249 deliveries	192,579	175,247	157,915	119,399	140,583	97,252	90,512
571	H	--250 to 269 deliveries	205,418	186,930	168,443	127,359	149,955	103,736	96,546
572	H	--270 to 289 deliveries	218,259	198,616	178,972	135,320	159,329	110,221	102,582
573	H	--290 to more deliveries	231,095	210,297	189,498	143,279	168,700	116,703	108,615
114	S	Surgery – Ophthalmology	45,753	41,636	37,518	28,367	33,400	23,105	21,504
804	S	Surgery – Ophthalmology – Plastic	59,866	54,478	49,090	37,117	43,702	30,232	28,137
154	H	Surgery – Orthopedic	157,096	142,958	128,819	97,400	114,680	79,334	73,835
164	H	Surgery – Orthopedic – without procedures on the back	115,759	105,341	94,923	71,771	84,504	58,458	54,407
158	S	Surgery – Otology	59,041	53,727	48,413	36,605	43,100	29,816	27,749
159	S	Surgery – Otorhinolaryngology	59,041	53,727	48,413	36,605	43,100	29,816	27,749
156	H	Surgery – Plastic – not otherwise classified	94,692	86,170	77,647	58,709	69,125	47,819	44,505
155	S	Surgery – Plastic Otorhinolaryngology	89,669	81,598	73,528	55,595	65,458	45,283	42,144
160	S	Surgery – Rhinology	59,041	53,727	48,413	36,605	43,100	29,816	27,749
144	H	Surgery – Thoracic	129,202	117,574	105,946	80,105	94,318	65,247	60,725
171	H	Surgery – Traumatic	128,187	116,650	105,113	79,476	93,576	64,734	60,248
145	S	Surgery – Urological	54,013	49,152	44,290	33,488	39,429	27,276	25,386
146	H	Surgery – Vascular	146,709	133,505	120,301	90,960	107,098	74,088	68,953
120		Urology-minor	35,108	31,949	28,789	21,767	25,629	17,730	16,501
424		Urgent Care Medicine	34,973	31,825	28,678	21,683	25,530	17,661	16,437

Note: When $2,000,000/$4,000,000 Increased Limits Factor (ILF) is requested for a specialty code that displays an alpha code, either S or H, use the corresponding ILF factor as displayed in Rule F.

C. Mature Claims-Made Rates – Dentists

Specialty Code	Specialty Description	Terr. 1	Terr. 2	Terr. 3	Terr. 4	Terr. 5	Terr. 6	Terr. 7
212	Dental Surgeons – Oral or Maxillofacial – Engaged in oral surgery or operative dentistry on patients rendered unconscious through the administering of any anesthesia or analgesia	38,655	35,176	31,697	23,966	28,218	19,521	18,168
210	Dentists – Minor Surgery	19,329	17,589	15,849	11,984	14,110	9,761	9,084
211	Dentists – No Surgery - not otherwise classified	7,731	7,035	6,340	4,793	5,644	3,904	3,634

D. Mature Claims-Made Rates – Health care Facilities

1. Emergency Room Groups*

ILFs Alpha Code	Specialty Description	Terr. 1	Terr. 2	Terr. 3	Terr. 4	Terr. 5	Terr. 6	Terr. 7
S	Emergency Room Groups ("Per 100 patient visits" basis). Separate limits per member physician/health care professional may be purchased for an additional 20% charge of the "per patient visit" premium.	1,993	1,814	1,634	1,236	1,455	1,007	937

2. Urgent Care Groups*

ILFs Alpha Code	Specialty Description	Terr. 1	Terr. 2	Terr. 3	Terr. 4	Terr. 5	Terr. 6	Terr.7
	Urgent Care Groups ("Per 100 patient visits" basis). Separate limits per member physician/health care professional may be purchased for an additional 20% charge of the "per patient visit" premium.	560	510	459	347	409	283	263

3. Outpatient Surgery Centers*

ILFs Alpha Code	Specialty Description	Terr. 1	Terr. 2	Terr. 3	Terr. 4	Terr. 5	Terr. 6	Terr.7
S	Outpatient Surgery Centers (Surgicenters) ("Per 100 patient visits" basis). All physicians must be separately insured by American Physicians in order to provide coverage for the outpatient surgery center.	2,833	2,578	2,323	1,756	2,068	1,431	1,331

4. Additional Health care Facility Rates (per $1000 receipts basis)*

ILFs Alpha Code	X-Ray / Imaging Laboratory/Code 88526	Terr. 1	Terr.2	Terr.3	Terr.4	Terr 5	Terr5	Terr 7
		7.43	7.43	7.43	7.43	7.43	7.43	7.43

E. Premium Charges for Vicarious, Shared and Separate Limits
Under Countrywide Rule IX., Item D., Premium Charges for Vicarious, Shared and Separate Limits is replaced in its entirety with the following:

Specialty Code	Health care Professional	Vicarious Limit Charge	Shared Limit Charge (based upon retroactive date of Named Insured)	Separate Limit Charge (based upon retroactive date of Health care Professional)
411	Chiropractor	0%	10% of class 420	20% of class 420
452	Nurse Anesthetist	0%	3% of class 151	6% of class 151
962	Nurse Midwife	0%	10% of class 153	20% of class 153
963	Nurse Practitioner	0%	3% of class 420	6% of class 420
942	Perfusionist	0%	3% of class 420	6% of class 420
807	Physician Assistant	0%	3% of class 420	6% of class 420
943	Podiatrist/incl. surg.	0%	21% of class 143	42% of class 143
944	Podiatrist – no surg.	0%	33% of class 420	66% of class 420
946	Psychologist	0%	3% of class 249	6% of class 249
808	Surgeon Assistant	0%	3% of class 420	6% of class 420

F. Higher limits of liability may be purchased at premiums derived by applying the following factors to the $1,000,000/$4,000,000 rates:

Higher Limits of Liability	All Other Physicians and Dentists	Emergency Medicine, Radiologists, All Other Surgery **(S)**	Selected Surgical Specialties **(H)**
$2,000,000/$4,000,000	1.344	1.418	1.460

For higher Limits of Liability – Refer to Company

G. Limits that are less than these $1,000,000/$4,000,000 may be purchased at premiums derived from applying the following decreased limit factors to the $1,000,000/$4,000,000 rates (not including any credit applied for a deductible):

Limits of Liability	All Physicians, Surgeons, and Dentists
$100,000/$400,000	0.480
$200/000/$800,000	0.620
$250,000/$1,000,000	0.665
$300,000/$1,200,000	0.700
$500,000/$2,000,000	0.790
$750,000/$3,000,000	0.920
$1,000,000/$2,000,000	0.980
$1,000,000/$4,000.000	1.000

H. Claims-Made Maturity Factors

Note: If the retroactive date falls on a date other than the anniversary date, a factor will be used that is pro-rating the two applicable maturity factors. These factors are applied to the mature claims-made base rates.

First Year	0.25
Second Year	0.40
Third Year	0.75
Fourth Year	0.90
Fifth Year	0.95
Sixth Year	0.98
Mature	1.00

I. Under Countrywide Claims Made Extended Reporting Endorsement Coverage Rule VI., Item G. is deleted in its entirety and replaced with the following:

Claims Made Extended Reporting Endorsement Rule

Claims-made reporting period extension(s) ("tail" coverage) are offered (unless coverage is automatically provided within the terms of the policy) to any insured whose coverage is terminated for any reason.

1. Tail provision #1 – For new or renewal policies effective May 1, 2009 and after and cancelled effective after May 1, 2009, the following option will apply:
   a. A single extension for an unlimited reporting period may be purchased. One set of limits of liability is provided for the entire unlimited reporting period. The rates for this extension are computed by applying the applicable reporting period extension factor displayed in Item J. shown below to the annual expiring premium. A suspension of coverage discount will not be included in the determination of the annual expiring premium. Payment is due in one lump sum or payments may be spread equally over three annual installments. No installment charge will apply.

2. Tail provision #2 – For new or renewal policies effective prior to May 1, 2009 and cancelled effective May 1, 2009 and after, the following two options apply:
   a. A single extension for an unlimited reporting period may be purchased. One set of limits of liability is provided for the entire unlimited reporting period. The rates for this extension are computed by applying the applicable reporting period extension factor displayed in Item J. shown below to the annual expiring premium. A suspension of coverage discount will not be included in the determination of the annual expiring premium.
   b. Alternatively, three extensions may be issued. One as of the policy termination date and the subsequent two anniversaries of the termination date. Separate limits apply for each of the three extensions. The final extension is an unlimited extension. Premiums for each extension are 33.3% of the rate applicable to the single unlimited extension. A suspension of coverage discount will not be included in the determination of the annual expiring premium.

3. Tail provision #3 – For policies already cancelled effective May 1, 2009 and prior, the following option will apply:
   a. The remaining extension(s) of the three extensions option may be purchased as of the policy termination date and the anniversary (ies) of the termination. Separate limits apply for each of the extension(s). The final extension is an unlimited extension. Premiums for each extension are 33.3% of the rate applicable to the single extension.

J. Factors are applied to the claims-made rate applicable to the annual expiring policy at the time the extended reporting endorsement is offered.

First Year	4.00
Second Year	3.88
Third Year	2.40
Fourth Year	2.11
Fifth Year	2.05
Sixth Year	2.01
Mature	1.97

K. Corporate Entity Coverage

Under Countrywide Corporate Entity Coverage Rule, Item A. is deleted in its entirety and replaced with the following:

A. Organization Coverage – Shared Limits (Non-Stacking)
A professional association, corporation or other similar professional legal entity will be the named insured with no additional limits of insurance applicable to the organization. Physicians and eligible health care professionals will be scheduled on the same policy with a separate limit of liability.

Reporting extension coverage (tail) will be offered to the physicians and eligible health care professionals according to rules stated in these exception pages. A reporting extension coverage (tail) will be given to the organization if at least one physician purchases their tail. In the event no physicians purchase their tail, the corporate entity will have no tail coverage. An option to purchase the corporate tail coverage will be offered at 20% of the member's tail premiums.

Under Countrywide Corporate Entity Coverage Rule, Item B. Organization Coverage Charge – Separate Limits (Stacking), sub item 3. is replaced with the following:

3.

# of Insureds	Charge
2-5	15.0%
6-9	12.0%
10-19	9.0%
20 or more	7.0%

L. Part-Time Rule

Under Countrywide Rule VI. Special Rating Rules, Item A. Part Time is replaced with the following:

A. Part Time: 60% of the otherwise applicable rate applies to physicians (see eligibility requirements under General Rules) with American Physicians insured exposure averaging 20 hours or less per week. If evidence of insurance is provided for any professional liability exposure insured by any other carrier, that other exposure would be excluded from the American Physicians policy. Other credits may be reduced due to lower premiums with this rating.

XIII. Merit Rating

In order to be eligible for any merit-rating plan, the incurred loss ratio over the last 10 years shall not exceed **135%**. The total credit that may be applied under the Claims-Free Credit Rule is **-15%** and the total credit/debit that may be applied under the Schedule Rating Plan is **+/- 35%.**

A. Claim-Free Credit

See countrywide manual Section X. Merit Rating, Rule A. for the underwriting criteria.
Rule 1. is deleted in its entirety and replaced with the following. 1. The company will allow a credit to those applicants and insureds who have maintained a practice without substantial change for at least the immediately prior three years and who have incurred no claims for the immediately prior three or more years. A claim resulting in cumulative expense payments up to $10,000 will not count as a claim.

Below is the Claim-Free Credit Schedule for use in Illinois:

1. Credit Schedule:

Years of Claims-Free Experience	Credit
Three to Five Years	5%
Six to Seven Years	10%
Eight or More Years	15%

B. Schedule Rating Plan

The premium may be credited or debited based on the total of credits and debits derived from the following "risk characteristics" schedule. The maximum allowable credit/debit for the Schedule Rating Plan is **+/- 35%.**

	Maximum Credit	Maximum Debit
1. Professional Skills, Quality of Care Use of a recognized system of clinical guidelines. Relevant board certification. Accreditation status by a recognized regulatory body. The provision of medical care limited to qualified individuals. Continuing education of all professional staff beyond what is required by state licensing regulation. Maintenance of premises and equipment.	10%	10%
2. Patient Rapport Length of service and reputation in community. Established policies and procedures for patient services. Cooperation with the Company claims management and resolution procedures.	10%	10%
3. Record Keeping A well-maintained patient record system in place: thorough documentation of patient care and interaction; follow-up system for diagnostic studies, consultation and appointments.	10%	10%
4. Risk Characteristics	5%	5%
a. Documented successful completion of an approved office risk analysis/communication skills assessment/risk management on-site visit and/or education program, including an appropriate response to recommendations made.		
b. Documented attendance at an approved risk management seminar, or successful completion of an approved risk management correspondence course.		

XIV. Quarterly Installment Option and Monthly Installment Option

American Physicians offers the following: (does not apply to Claims-Made Reporting Period Extensions ("tail coverage").

4-pay (quarterly)	25% down payment	3 equal installments (Due 4th, 7th, and 10th months).
9-pay (monthly)	15% down payment	8 equal installments (Due 2nd, 3rd, 4th, 5th, 6th, 7th, 8th, and 9th months).

- A $10 installment fee will be applied to all payment plans/per installment. No interest will be charged.

XV. Deductibles

See Countrywide Manual, Section V. for underwriting criteria.
Item C. from the Deductible section in the Countrywide Manual is deleted and replaced with the following: Deductible factors are applied to the $1,000,000/$4,000,000 base rate, Section IV, Rating Steps, Item D to derive the deductible credit amount.

Deductible Amount Per Incident	Indemnity Only Factor	Indemnity and Defense Factor
$5,000	.01	.03
$10,000	.03	.05
$15,000	.04	.08
$25,000	.07	.12
$30,000	.08	.13
$50,000	.12	.19
$75,000	.16	.25
$100,000	.19	.30
$200,000	.27	.43

XVI. Risk Management Activities Discounts

See Section XIII. Merit Rating, Rule B., Schedule Rating Plan, sub item 4 – Risk Characteristics on page IL-9 for the Underwriting Criteria.

XVII. Consent to Rate

Under Countrywide Rules, Rule XI. Consent to Rate is deleted in its entirety.

XVIII. Individual Risk

Individual rating may be done for specific risks that have unique hazards and unique expenses. subject to underwriting approval.

I. GENERAL INSTRUCTIONS

A. This manual contains the rules, rating classifications and rates governing the underwriting of healthcare provider professional liability insurance by American Physicians Assurance Corporation (the Company).

B. The rules, classifications and rates in this manual are effective as of the date indicated on each page. When a change is made, a reprinted page containing the change and its effective date is distributed. The change is specifically designated by an asterisk (*) on the outer margin of the affected page(s).

C. Specific exceptions to these rules are indicated in the appropriate state rate and rules exception pages.

II. GENERAL RULES

A. Rates:

Premiums are calculated by using mature claims-made base rates exhibited in the state rate and rules exception pages for limits of $1,000,000/$3,000,000 and by applying applicable claims-made maturity factors or other coverage option factors.

1. Classification and territory are based on healthcare practice as insured by the Company. Portions of an insured healthcare practice that are uninsured, or are insured by another carrier, may be excluded from coverage and are not considered in determining the appropriate rating classification.

2. Additional charges provided under any rate schedule in this manual measure the liability of an insured for the exposures covered by those additional charges. Additional charges must be obtained where those exposures exist and are insured.

B. Minimum Premium:

$500 is the minimum annual policy premium. This also applies to any short-term policy.

The calculation of premium for short term policies, i.e., policies written for a period of less than one year, shall be computed on a pro-rata basis.

C. Claims Made Extended Reporting Endorsement:

1. Claims-made reporting period extension(s) ("tail coverage") are offered to any insured whose coverage is terminated for any reason. (Unless coverage is automatically provided within the terms of the policy).

D. Part-Time Eligibility:

1. A physician may be granted a part-time discount if they work 20 hours or less per week. Practice hours consist of: hospital rounds, on-call hours involving patient contact, consultation with other physicians, patient visits and charting hours. The physician must also meet at least one of the eligibility requirements listed below. Discount is subject to underwriting approval.

2. Certain specialties are not eligible regardless of number of hours, including but not limited to; surgeons, medical directors of nursing homes, first year and second year physicians etc. A physician who chooses to "work less" than full time is not eligible.

3. When picking up prior acts coverage for a physician who was previously on a full-time basis, physician does not qualify for part-time for two years.

4. Eligibility requirements:

   a) Semi-retired if 55 years or older.
   b) Reduced practice due to disability (must have written explanation from treating physician)
   c) Reduced practice due to pregnancy or dependent care.
   d) Majority of practice is insured through another entity, employer or carrier.
   e) Majority of time is spent in a teaching capacity.
   f) Majority of employment insured through a hospital.
   g) Majority of employment in another state which is insured elsewhere.

E. Prior Acts/Retroactive Coverage:

1. The retroactive date of a claims-made policy is the initial effective date of continuous coverage by the Company, except when the Company and the insured agree that the retroactive date should precede the initial effective date (prior acts, or, "nose" coverage). Subject to underwriting approval.

2. The rates for prior acts/retroactive coverage are adjusted to reflect any significant differences in exposure during the period for which prior acts coverage is written.

III. CLASSIFICATION PROCEDURE

A. For Classification assignment:

1. The term "no surgery" applies to general practitioners and specialists who do not perform obstetrical procedures or surgery and who do not assist in surgical procedures. Incision of boils and superficial abscesses, removal of superficial growths, or suturing of skin and superficial fascia are not considered surgical procedures.

2. The term "minor surgery" applies to general practitioners and specialists who perform endoscopies (other than colonoscopy, proctoscopy, or sigmoidoscopy), vasectomies, hemorrhoidectomies, diagnostic D & C's, vacuum curettage abortions during the first trimester of pregnancy, other similar invasive procedures, or assist in major surgery on their own patients.

3. The term "major surgery" applies to general practitioners and specialists who perform any surgery other than "minor surgery", and to those who assist in major surgery on other than their own patients.

B. If two or more rating classifications apply, the rate for the highest rated classification is used.

IV. KEY RATING STEPS

For each individual physician, surgeon, or ancillary personnel purchasing separate limits, premium is determined by performing the following calculations.

A. Obtain mature claims-made base rate from the state exception page using the assigned specialty and territory.

B. Multiply the result in Step A by the appropriate special rating rule factor for part-time practice, first or second year practice, or moonlighting resident (see Rule VI).

C. Determine the appropriate decreased/increased limit factor (ILF) based on the policy limits desired and multiply the result of step B by it.

D. If a deductible applies, determine the deductible credit amount by multiplying the result of step B by the deductible factor from Rule V-C. Subtract this deductible credit amount from the result of step C.

E. Apply the appropriate factor for the reporting period coverage being offered:

1. Occurrence: Apply the appropriate factor from the state exception page.
2. TailGard®: Apply the appropriate factor from the state exception page.
3. Claims-made: Apply the appropriate step factor from the state exception page based on the physician's claims-made retroactive date and state specific rules.

F. Determine the applicable merit rating adjustments from Rule X and state exception pages. Multiply the sum of the adjustments times the Standard Premium to determine the Merit Rating Credit.

G. Subtract the Merit rating Credit from the Standard Premium and round to the nearest whole dollar. If this amount is less than minimum premium in Rule II-B, then the minimum premium applies.

If separate limits are desired for the corporate entity, calculate the additional corporation premium as follows:

H. Sum the individual Standard Premiums for all physicians and ancillary personnel calculated above.

I. Multiply this sum by the appropriate group coverage factor in the state exception pages and round to the nearest whole dollar.

J. The premium for Healthcare Facilities is based on a rate per 100 annual patient visits or per $1,000 annual receipts basis.

V. DEDUCTIBLES

A. Definition: A deductible makes the Insured responsible for ultimately paying a portion of any sums paid by the Company under the policy. The deductible may apply to either indemnity (payments of settlements and judgments), expense (lawyer's fees, deposition costs, etc) or both. The Company will adjust the loss as usual and then request reimbursement from the Insured for his share of the loss or expense. The deductible carries a per claim limit and an annual aggregate. The Insured pays up to the per claim limit on any one claim and continues to do so on succeeding claims until the annual aggregate is exhausted.

B. Eligibility Requirements

1. Deductibles may be written on claims-made policies only

2. The deductible aggregate is three times the per claim limit. The aggregate may be increased at the discretion of the underwriter based on loss history, or if the size of the group and expected losses warrant a higher aggregate.

3. An "evergreen" Letter of Credit (LOC) for the aggregate amount is always required as a prerequisite to including a deductible on any policy. A LOC is a contract between the Insured and a financial institution. It guarantees that the institution will loan the Insured up to a specified amount of money at any time while the letter is in effect. The existence of the letter assures the Company that they will be reimbursed for any sums they pay under the deductible. "Evergreen" means that the LOC contains a provision automatically renewing it on the expiration date, unless proper notice is given. The underwriter should make certain that he or she is included by first copy on the chain of correspondence between the financial institution and the Insured, so that the Company may immediately react to any attempted alteration in the LOC's

terms. The Company reserves the right to "draw down" the LOC and hold the funds in escrow for payment of claims if the Insured fails to renew the LOC.

4. At renewal, the Insured must present an LOC to the Company in an amount equal to the deductible aggregate plus the indemnity reserves (and expense reserves if a loss and expense deductible is selected) for any claims opened in the prior policy year(s).

5. The deductible does not apply to any Extended Reporting Endorsement ("tail") which may be attached to the policy.

6. The amount of the deductible should be appropriate to the policy's written premium and the relative financial stability of the Insured. As a general guideline, the deductible should not exceed 20% of the policy's written premium.

C. Deductible factors are applied to the $1,000,000/$3,000,000 base rate, Section IV, Rating Steps, Item D to derive the deductible credit amount. Deductibles are not available in KY.

Deductible Amount Per Incident	Indemnity Only Factor	Indemnity and Defense Factor
$5,000	.01	.03
$10,000	.03	.05
$15,000	.04	.08
$25,000	.07	.12
$30,000	.08	.13
$50,000	.12	.19
$75,000	.16	.25
$100,000	.19	.30
$200,000	.27	.43

D. PL CM 50, Deductible – Indemnity Only is to be use with Indemnity Only Factors and PL CM 52, Deductible – Indemnity and Defense Single Limit is to be use with Indemnity & Defense Factors.

VI. SPECIAL RATING RULES

A. Part Time: The part time rate applies to physicians (see eligibility requirements under General Rules) with the Company-insured exposure averaging 20 hours or less per week. If evidence of insurance is provided for any professional liability exposure insured by any other carrier, that other exposure would be excluded from the Company policy. Other credits may be reduced due to lower premiums with this rating. See state exception manual pages for the applicable part time rate.

B. First Year Physician: 50% of the otherwise applicable rate applies to physicians and surgeons beginning practice within twelve months after having completed post-graduate internship and/or residency. This discount also applies to the following:

1. Military: To an insured if separated from active military service, without having had any previous practice of any kind.

2. Foreign Country: To a first year physician that practices in the United States if they only previously practiced in a foreign county.

C. Second Year Physician: 70% of the otherwise applicable rate applies to a second year physician.

D. Moonlighting Resident: 25% of the otherwise applicable rate applies to residents employed part-time outside their residency. The applicable rate is based on their employment practice, not their residency training. Coverage for the residency training itself is excluded.

1. Requirements
   a. The moonlighting resident must have written approval of his or her residency program for outside "moonlighting" employment in order for the Company to offer coverage.
   b. If a moonlighting resident is joining a group, we do require that we write the group.

E. Suspension of Coverage: Upon an insured's temporary leave from active practice for reasons of health, education, military service, maternity or other appropriate reason as judged by the Company, for a period of at least three months and not more than 36 months, claims-made coverage may be "suspended".

1. 20% of the otherwise applicable premium will be charged, subject to minimum premium.

F. Multiple Territory Exposure: If a doctor has exposure in 2 or more different rating territories, the rate for the highest rated territory is used.

G. Claims-Made Extended Reporting Endorsement: Two options are available as described below:

1. A single extension for an unlimited reporting period may be purchased. One set of limits of liability is provided for the entire unlimited reporting period. The rates for this extension are computed by applying the applicable reporting period extension factor exhibited in the state rate pages to the current claims-made rate in effect at the time the tail is issued. Merit rating does not apply to this calculation.

2. Alternatively, three extensions may be issued. One as of the policy termination date and the subsequent two anniversaries of the termination date. Separate limits apply for each of the three extensions. The final extension is an unlimited extension. Premiums for each extension are 35% of the rate applicable to the single unlimited extension. The Reporting Period Extension Factors are applied to current claims-made rates in effect on each subsequent anniversary date. Merit rating does not apply to this calculation. Exception: IL – see state exception pages for the appropriate Claims-Made Extended Reporting Endorsement Rule.

VII. OPTIONAL COVERAGES

A. Locum Tenens Physician

1. A substitute physician is included in the insured's policy at no charge until a cumulative period of substitution in one policy period is greater than 30 days.

2. The Company may, at its discretion, allow an additional substitution period or periods to be written beyond this 30-day limit for an additional premium equal to the pro-rata portion of the insured's premium for the period of substitution, subject to a $500 minimum premium.

B. Prior Acts/Retroactive Coverage:

1. Coverage is rated according to the application of claims-made maturity factors exhibited in the state rate pages to current mature base rate. The claims-made maturity factor used is that which best reflects the maturity of coverage. If the retroactive date falls on a date other than an anniversary date (1st year, 2nd year, etc.) for which factors are exhibited in the state rate pages, the claims-made factor will be derived on a pro rate basis from the two closest claims-made maturity factors.

C. Occurrence Coverage:

The Company offers occurrence coverage in a limited number of states (IN, MI and NM). Please see the state exception pages for rates and rules regarding occurrence coverage.

D. TailGard® Coverage:

1. The Company, offers claims-made coverage with promise to provide a reporting period extension ("tail") for no charge at the end of the continuous sequence of coverage on this basis in MI only.

2. The cost of claims-made coverage including this pre-paid "tail" is the same as the mature claims-made rate, regardless of the otherwise applicable claims-made maturity factor.

3. The first policy of a sequence of policies on this basis must begin on a retroactive date, which is the inception date.

VIII. CORPORATE ENTITY COVERAGE

A. Organization Coverage – Shared Limits (Non- Stacking)

A professional association, corporation or other similar professional legal entity may be included as an additional insured with no additional limits of insurance for no additional charge.

B. Organization Coverage – Separate Limits (Stacking)

1. A professional association, corporation, partnership or other legal entity that employs more than one physician may purchase a separate limit of liability. See state exception manual pages for IN and WI.

2. This policy is written at limits of liability no greater than the lowest limit written on behalf of any of the owners or members of the organization.

3. The organization coverage charge is a percentage of the applicable rate of the premiums applicable to the professional partners, stockholders, and employees of the organization entity will be charged to arrive at the premium for the separate organization limit charge. See state exception manual pages for the applicable percentage rate.

4. Employees of the organization required by state law or regulation to maintain professional license certifications or registrations with respect to the scope of duties performed may be subject to vicarious or shared limits charge as defined in the additional charges section of the manual.

C. Affiliated Physician

If an employee has insurance for at least the limits of insurance of the named insured from a carrier other than the Company, 15% of the rate otherwise applicable to the employee's specialty can be charged. Subject to underwriting approval.

IX. ADDITIONAL CHARGES:

The following charges for ancillary employees will be applied to an individual physician or surgeon policy. If a corporate entity separate limit policy is written, the charges will be applied to the applicable corporate entity policy. Coverage form and limits of liability must be the same as the individual physician or surgeon policy or the corporate entity separate limit policy.

A. Vicarious Exposure Charges

1. Premium charges are made based on the additional exposure to the employers created by employment. No coverage is provided on behalf of the employee(s) as an additional insured.

2. These charges are according to rates exhibited in Item D., which are added to the insured's premium.

3. These charges may be waived if direct insurance on behalf of the employee(s) is purchased through the Company.

B. Additional Insured – Shared Limits

1. Certain categories of employees may be added as additional insureds with no increase in limits of insurance, according to rates exhibited below in Item D.

2. The premiums developed from these factors are to be added to insured's premium before application of named insured maturity factors.

C. Additional Insureds – Separate Limits

1. Certain categories of employees may be added as additional insureds with separate additional limits of insurance applicable, according to rates included in the following schedule shown in Item D. A completed healthcare provider application will be required when separate limits are requested.

2. Separate limits are available only for the listed healthcare professionals shown in Item D. The retroactive date applicable to that employee must be provided and the employee's maturity factor will be applied when separate limits are written.

D. Premium Charges for Vicarious, Shared, and Separate Limits

Specialty Code	Healthcare Professional	Vicarious Exposure Charge	Shared Limit Charge	Separate Limit Charge
411	Chiropractor	25% of class 420	35% of class 420	70% of class 420
452	Nurse Anesthetist	5% of class 151	7.5% of class 151	15% of class 151
962	Nurse Midwife	10% of class 153	25% of class 153	50% of class 153
963	Nurse Practitioner	5% of class 420	7.5% of class 420	15% of class 420
942	Perfusionist	5% of class 420	7.5% of class 420	15% of class 420
807	Physician Assistant	5% of class 420	7.5% of class 420	15% of class 420
943	Podiatrist/ incl. surg.	25% of class 143	40% of class 143	50% of class 143
944	Podiatrist – no surg.	20% of class 420	35% of class 420	70% of class 420
946	Psychologist	No Charge	5% of class 249	10% of class 249
808	Surgeon Assistant	5% of class 420	7.5% of class 420	15% of class 420

X. MERIT-RATING

In order to be eligible for any merit-rating plan, the incurred loss ratio over the last 10 years shall not exceed a specified percentage. Please refer to rates, state rule exception pages for details.

A. Claim-free Credit

1. The Company will allow a credit to those applicants and insureds who have maintained a practice without substantial change for at least the immediately prior three years and who have incurred no claims for the immediately prior three or more years. This credit is in addition to any scheduled credit or debit.
2. The time frame for any claim is based on the date the claim is reported.
3. This credit does not apply to part-time physicians.
4. Credit schedule - See state exception manual pages for the applicable credit schedule):

B. Schedule Rating Plan

Based upon the Underwriters overall evaluation, an exposure may justify a modification (credit/debit) to the otherwise applicable premium based on one or more of the following individual risk characteristics. Please note: these are guidelines and are not intended to be a comprehensive list of every consideration.

Please refer to rates, state rule exception pages for details regarding maximum credits/debits.

Schedule of Individual Risk Characteristics:

1.	Professional Skills, Years of experience in the practice of medicine
2.	Board Certification
3.	Longevity with American Physicians
4.	Established policies and procedures
5.	Cooperation with claims management
6.	Risk Management Practices (including but not limited to the following :) a) Communication Skills Assessment (CSA) 1) Recommended 2) Underwriter Discretion 3) Not Recommended b) On-Site Risk Management Assessment 1) Excellent 2) Above Average 3) Average 4) Below Average
7.	Number and type of patient exposures/practice hours
8.	Continuing Medical Education/Adequate training
9.	Training, accreditation, credentialing, privileges, professional society membership, and hospital affiliations

XI. CONSENT TO RATE

A. A physician or surgeon may be an acceptable professional liability insurance risk only at rates higher than otherwise available through this manual.

B. In the event that a higher rate is warranted based on the claims history or other circumstances, an individual rate filing signed by the insured or the applicant is filed as required by, and to the satisfaction of the appropriate state insurance department or bureau.

Contact Person:
Gayle Neuman
217-524-6497
Gayle.Neuman@illinois.gov

Illinois Division of Insurance
Review Requirements Checklist

320 West Washington Street
Springfield, IL 62767-0001

Effective as of 8/25/06

From: Patty Edgington at American Physicians Assurance Corp, NAIC #33006, Fein #38-2102867

Co Filing #IL-2009-03

Line(s) of Business	Code(s)	
_x__**MEDICAL MALPRACTICE**	**11.0000**	***This checklist is for rate/rule
_x_Claims Made	11.10000	**filings only.**
___Occurrence	11.2000	**See separate form checklist.**

Line(s) of Insurance	Code(s)	Line(s) of Insurance	Code(s)	Line(s) of Insurance	Code(s)
___Acupuncture	11.0001	___Hospitals	11.0009	___Optometry	11.0019
___Ambulance Services	11.0002	___Professional Nurses	11.0032	___Osteopathy	11.0020
___Anesthetist	11.0031	___Nurse – Anesthetists	11.0010	___Pharmacy	11.0021
___Assisted Living Facility	11.0033	___Nurse – Lic. Practical	11.0011	___Physical Therapy	11.0022
___Chiropractic	11.0003	___Nurse – Midwife	11.0012	_x_Physicians & Surgeons	11.0023
___Community Health Center	11.0004	___Nurse – Practitioners	11.0013	___Physicians Assistants	11.0024
___Dental Hygienists	11.0005	___Nurse – Private Duty	11.0014	___Podiatry	11.0025
___Dentists	11.0030	___Nurse – Registered	11.0015	___Psychiatry	11.0026
___Dentists – General Practice	11.0006	___Nursing Homes	11.0016	___Psychology	11.0027
___Dentists – Oral Surgeon	11.0007	___Occupational Therapy	11.0017	___Speech Pathology	11.0028
___Home Care Service Agencies	11.0008	___Ophthalmic Dispensing	11.0018	___Other	11.0029

Illinois Insurance Code Link	Illinois Compiled Statutes Online	
Illinois Administrative Code Link	Administrative Regulations Online	
Product Coding Matrix Link	Product Coding Matrix	
NAIC Uniform Transmittal Form	50 IL Adm. Code 929 NAIC Uniform Transmittal Form	If insurers wish to use the NAIC Uniform Transmittal form in lieu of a cover letter/explanatory memorandum, the Division will accept such form, as long as all information required in the "Cover Letter & Explanatory Memorandum" section below are properly included.
NAIC Self-Certification Pilot Program	Newsletter Article regarding Division's Participation Self-Certification form	If an authorized company officer completes the Self-Certification form, and submits such form as the 1st page of the filing, the Division will expedite review of the filing ahead of all other filings received to date. The Division will track company compliance with the laws, regulations, bulletins, and this checklist and report such information to the NAIC.
Location of Standard within Filing Column	See checklist format below.	To expedite review of your filing, use this column to indicate location of the standard within the filing (e.g. page #, section title, etc.)
Description of Review Standards Requirements Column	See checklist format below.	These brief summaries do not include all requirements of all laws, regulations, bulletins, or requirements, so review actual law, regulation, bulletin, or requirement for details to ensure that forms are fully compliant before filing with the Division of Insurance.

FILING REQUIREMENTS FOR FORM FILINGS	REFERENCE	DESCRIPTION OF REVIEW STANDARD REQUIREMENT	LOCATION OF STANDARD WITHIN FILING
See separate form filing checklist.		To assist insurers in submitting compliant medical liability rate/rule filings as a result of newly-passed PA94-677 (SB475), the Division has created this separate, comprehensive rate/rule filing checklist for medical liability filings. Please see the separate form filing checklist for requirements related to medical liability forms.	N/A – This is a rule filing.
GENERAL FILING REQUIREMENTS FOR ALL RATE/RULE FILINGS			
LINE OF AUTHORITY			
Must have proper Class and Clause authority to conduct this line of business in Illinois.	215 ILCS 5/4 List of Classes/Clauses	To write Medical Liability insurance in Illinois, companies must be licensed to write: 1. Class 2, Clause (c)	APA Certificate of Authority grants class 2, clause c authority, COA#967543-51
RATES AND RULES REQUIRED TO BE FILED			
Rates/Rules Must be Filed Separately from Forms			
Insurers shall make separate filings for rate/rules and for forms/endorsements, etc.		The laws and regulations for medical liability forms/endorsements and the laws for medical liability rates/rules are different and each must be reviewed according to its own set of laws/regulations/procedures. Therefore, insurers are required to file forms and rates/rules separately. For requirements regarding form filings, see separate form filing checklist.	This is a rule filing effective 5-1-09.
New Insurers			
New insurers must file their rates, rules, plans for gathering statistics, etc. upon commencement of business.	215 ILCS 5/155.18 50 IL Adm. Code 929	"New Insures" are insurers who are: • New to Illinois. • New writers of medical liability insurance in Illinois. • Writing a new Line of Insurance listed on Page 1 of this checklist, New insurers must file the following: a) Medical liability insurance rate manual, including all rates.	Not applicable with this filing. We are not a new insurer.

		b) Rules, including underwriting rule manuals which contain rules for applying rates or rating plans, c) Classifications and other such schedules used in writing medical liability insurance. d) Statement regarding whether the insurer: • Has its own plan for the gathering of medical liability statistics; or • Reports its medical liability statistics to a statistical agent (and if so, which agent). The Director, at any time, may request a copy of the insurer's statistical plan or request the insurer to provide written verification of membership and reporting status from the insurer's reported statistical agency. Insurers are instructed to review all requirements in this checklist, including the requirements for applicable actuarial documentation, as well as all medical liability laws and regulations, to ensure that the filing contains all essential elements before submitting the filing to the Division.	
Amendments to Initial Rate/Rule Filings			
After a new insurer has filed the rates/rules/information described above, insurers must file rates/rules, or advise of changes to statistical plans, as often as they are amended.	215 ILCS 5/155.18 50 IL Adm. Code 929	After a new insurer has filed the rates/rules/information described above, insurers must file rates/rules/rating schedules (as described above for new business) as often as such filings are changed or amended, or when any new rates or rules are added. Any change in premium to the company's insureds as a result of a change in the company's base rates or a change in its increased limits factors shall constitute a change in rates and shall require a filing with the Director. Insurers shall also advise the Director if its plans for the gathering of statistics has changed, or if the insurer has changed statistical agents. The Director, at any time, may request a copy of the insurer's statistical plan or request the insurer to provide written verification of membership and reporting status from the insurer's reported statistical agency. Insurers are instructed to review all requirements in this checklist, including the requirements for applicable actuarial documentation, as well as all medical liability laws and regulations, to ensure that the filing contains all essential elements before submitting the filing to the Division.	Manual pages have been updated with changes highlighted.
EFFECTIVE DATES OF RATE/RULE FILINGS			
Illinois is "file and use" for medical liability rates and rules.	215 ILCS 5/155.18 50 IL Adm. Code	A rate/rating plan/rule filing shall go into effect no earlier than the date the filing is received by the Division of Insurance, Property & Casualty	Filing is being mailed 3-12-09 to be effective 5-1-09.

	929	Compliance Section, except as otherwise provided in Section 155.18.	
ADOPTIONS OF ADVISORY ORGANIZATION FILINGS			
Insurer must file all rates and rules on its own behalf.	50 IL Adm. Code 929	Although Rule 929 allows for insurers to adopt advisory organization rule filings, advisory organizations no longer file rules in Illinois.	We are filing on our own behalf.
COPIES, RETURN ENVELOPES, ETC.			
Requirement for duplicate copies and return envelope with adequate postage.	50 IL Adm. Code 929	Insurers that desire a stamped returned copy of the filing or submission letter must submit a duplicate copy of the filing/letter, along with a return envelope large enough and containing enough postage to accommodate the return filing.	Duplicate copy of filing in addition to return envelope with adequate postage is attached.
COVER LETTER & EXPLANATORY MEMORANDUM			
Two copies of a submission letter are required, and the submission letter must contain the information specified. "Me too" filings are not allowed. Use of NAIC Uniform Transmittal form is acceptable as long as all required information is included.	215 ILCS 5/155.18 50 IL Adm. Code 929 Company Bulletin 88-53 Actuarial Certification Form NAIC Uniform Transmittal Form	All filings must be accompanied by a submission letter which includes all of the following information: 1) Exact name of the company making the filing. 2) Federal Employer Identification Number (FEIN) of the company making the filing. 3) Unique filing identification number – may be alpha, numeric, or both. Each filing number must be unique within a company and may not be repeated on subsequent filings. If filing subsequent revisions to a pending filing, use the same filing number as the pending filing or the revision(s) will be considered a new filing. 4) Identification of the classes of medical liability insurance to which the filing applies (for identifying classes, refer to Lines of Insurance shown on Page 1 of this checklist, in compliance with the NAIC Product Coding Matrix). 5) Notification of whether the filing is new or supersedes a present filing. If filing supersedes a present filing, insurer must identify all changes in superseding filings, and all superseded filings, including the following information: • Copy of the complete rate/rule manual section(s) being changed by the filing with all changes clearly highlighted or otherwise identified. • Written statement that all changes made to the superseded filing have been disclosed. • List of all pages that are being completely superseded or replaced with new pages. • List of pages that are being withdrawn and not being replaced. • List of new pages that are being added to the	Submission letter attached with all items including the NAIC transmittal document. Included in submission letter and NAIC transmittal form. Included in submission letter and NAIC transmittal form. Included in cover letter and NAIC transmittal form. Included in NAIC transmittal form. Included in cover letter and NAIC transmittal form.

		superseded filing. • Copies of all manual pages that are affected by the new filing, including but not limited to subsequent pages that are amended solely by receiving new page numbers. 6) Effective date of use. 7) Actuarial certification (see Actuarial Certification section below). Insurers may use their own form or may use the sample form developed by the Division. 8) Statement that the insurer, in offering, administering, or applying the filed rate/rule manual and/or any amended provisions, does not unfairly discriminate. Companies under the same ownership or general management are required to make separate, individual company filings. Company Group ("Me too") filings are unacceptable. If insurers wish to use the NAIC Uniform Transmittal form in lieu of a cover letter/explanatory memorandum, the Division will accept such form, as long as all information required in this section is properly included.	Included in cover letter and NAIC transmittal form. The signed actuarial certification form is attached. Included in cover letter and NAIC transmittal form. Not applicable with this filing.
FORM RF-3 Summary Sheet			
For any rate change, duplicate copies of Form RF-3 must be filed, no later than the effective date.	50 IL Adm. Code 929 Form RF-3 Summary Sheet	For any rate level change, insurers must file two copies of Form RF-3 (Summary Sheet) which provides information on changes in rate level based on the company's premium volume, rating system, and distribution of business with respect to the classes of medical liability insurance to which the rate revision applies. Such forms must be received by the Division's Property & Casualty Compliance Section no later than the stated effective date of use. Insurers must report the rate change level and premium volume amounts on the "Other" Line and insert the words "Medical Liability" on the "Other" descriptive line. Do not list the information on the "Other Liability" line. If the Medical Liability premium is combined with any other Lines of Business (e.g. CGL, commercial property, etc.), the insurer must report the effect of rate changes to each line separately on the RF-3, indicating the premium written and percent of rate change for each line of business. The RF-3 form must indicate whether the information is "exact" or "estimated."	Not applicable with this filing. Not applicable with this filing. This is not applicable. This is not applicable.
PAYMENT PLANS			
Quarterly premium payment installment	215 ILCS 5/155.18	A company writing medical liability insurance in Illinois shall offer to each of its medical liability	We comply with these requirements.

plan required as prescribed by the Director.		insureds the option to make premium payments in quarterly installments as prescribed by and filed with the Director. Such option must be offered in the initial offer of the policy or in the first policy renewal occurring after January 1, 2006. Thereafter, the insurer need not offer the option, but if the insured requests it, must make it available. Such plans are subject to the following minimum requirements: • May not require more than 40% of the estimated total premium to be paid as the initial payment; • Must spread the remaining premium equally among the 2nd, 3rd, and 4th installments, with the maximum set at 30% of the estimated total premium, and due 3, 6, and 9 months from policy inception, respectively; • May not apply interest charges; • May include an installment charge or fee of no more than the lesser of 1% of the total premium or $25; • Must spread any additional premium resulting from changes to the policy equally over the remaining installments, if any. If there are no remaining installments, the additional premium may be billed immediately as a separate transaction; and • May, but is not required to offer payment plan for extensions of a reporting period, or to insureds whose annual premiums are less than $500. However, if offered to either, the plan must be made available to all within that group.	
DEDUCTIBLES			
Deductible plans should be filed if offered.	215 ILCS 5/155.18	A company writing medical liability insurance in Illinois is encouraged, but not required, to offer the opportunity for participation in a plan offering deductibles to its medical liability insureds. Any such plan shall be contained in a filed rate/rule manual section entitled "Deductibles Offered" or substantially similar title. If an insurer uses a substantially similar title, the Rate/Rule Submission Letter or NAIC Uniform Transmittal form must indicate the name of the section that applies.	See item XV titled Deductibles offered on page IL-11.
DISCOUNTS			
Premium discount for risk management activities should be filed if offered.	215 ILCS 5/155.18	A company writing medical liability insurance in Illinois is encouraged, but not required, to offer their medical liability insureds a plan providing premium discounts for participation in risk management activities. Any such plan shall be contained in a filed rate/rule manual section entitled "Risk Management Activities Discounts" or substantially similar title. If an insurer uses a substantially similar title, the Rate/Rule Submission Letter or NAIC Uniform Transmittal form must indicate the name of the	See item XVI titled Risk Management Activities Discounts on page IL-11.

		section that applies.	
CLAIMS MADE REQUIREMENTS			
Extended reporting period (tail coverage) requirements.	215 ILCS 5/143(2) Company Bulletin 88-50	When issuing claims-made medical liability insurance policies, insurers must include the following specific information in their rate/rule manuals: • Offer of an extended reporting period (tail coverage) of at least 12 months. The rate/rule manual must specify whether the extended reporting period is unlimited or indicate its term (i.e. number of years).*** • Cost of the extended reporting period, which must be priced as a factor of one of the following:*** o the last 12 months' premium. o the premium in effect at policy issuance. o the expiring annual premium. • List of any credits, discounts, etc. that will be added or removed when determining the final extended reporting period premium. • Insurer will inform the insured of the extended reporting period premium at the time the last policy is purchased. The insurer may not wait until the insured requests to purchase the extended reporting period coverage to tell the insured what the premium will be or how the premium would be calculated. • Insurer will offer the extended reporting period when the policy is terminated for any reason, including non-payment of premium, and whether the policy is terminated at the company's or insured's request. • Insurer will allow the insured 30 days after the policy is terminated to purchase the extended reporting period coverage.*** • Insurer will trigger the claims made coverage when notice of claim is received and recorded by the insured or company, whichever comes first. ***If the medical liability coverage is combined with other professional or general liability coverages, the medical liability insurer must meet all of the above requirements, except those indicated with ***, in which case, the insurer must: • Offer free 5-year extended reporting period (tail coverage) or • Offer an unlimited extended reporting period with the limits reinstated (100% of aggregate	See Item I, Reporting Period Extension Rules on page IL-7 and IL-8. See Item I, Reporting Period Extension Rules and Item J. Reporting Period Extension Factors on page IL-7 and IL-8. We comply with this rule. See Item I Reporting Period Extension rules and Item J Reporting Period Extension Factors on page IL-7 and IL-8. See Item I. Reporting Period Extension Rules and Item J, Reporting Period Extension Factors on page IL-7 and IL-8. See Item I, Reporting Period Extension Rules, Page IL-7 and IL-8. This is not applicable in this area so disregard. We do not include general liability or other professional coverages so this is not applicable with our company.

		expiring limits for the duration) • Cap the premium at 200% of the annual premium of the expiring policy; and • Give the insured a free-60 day period after the end of the policy to request the coverage.	
GROUP MEDICAL LIABILITY			
Group medical liability insurance is not specifically allowed under the Illinois Insurance Code.	50 IL Adm. Code 906	Part 906 of the Illinois Administrative Code prohibits writing of group casualty (liability) insurance unless specifically authorized by statute. The Illinois Insurance Code does not specifically authorize the writing of group medical liability insurance.	We are abiding by this rule.
CANCELLATION & NONRENEWAL PROVISION REQUIREMENTS			
If rate/rule manuals contain language pertaining to cancellation or nonrenewal, must comply with all cancellation/nonrenewal laws.	See Medical Liability Forms Checklist for Specific Information about Illinois Cancellation & Nonrenewal Laws and Regulations,	If a rate or rule manual contains language pertaining to cancellation or nonrenewal of any medical liability insurance coverage, such provisions must comply with all cancellation and nonrenewal provisions of the Illinois Insurance Code, including but not limited to the following: 143.10, 143.16, 143.16a, 143.17a. See Medical Liability Forms Checklist for Specific Information about Illinois Cancellation & Nonrenewal Laws and Regulations,	We comply with this rule.
ACTUARIAL REVIEW REQUIREMENTS			
Rates shall not be excessive, inadequate, or unfairly discriminatory.	215 ILCS 5/155.18	In the making or use of rates pertaining to all classes of medical liability insurance, rates shall not be excessive, or inadequate, nor shall they be unfairly discriminatory. Rate and rule manual provisions should be defined and explained in a manner that allows the Division to ascertain whether the provision could be applied in an unfairly discriminatory manner. For example, if a rate/rule manual contains ranges of premiums or discounts, the provision must specify the criteria to determine the specific premium/discount an insured or applicant would receive. The Director may, by order, adjust a rate or take any other appropriate action at the conclusion of a public hearing.	Rules being proposed with this filing are adequate, not excessive, and not unfairly discriminatory.
PRICING			

Insurers shall consider certain information when developing medical liability rates.	215 ILCS 5/155.18	Consideration shall be given, to the extent applicable, to past and prospective loss experience within and outside this State, to a reasonable margin for underwriting profit and contingencies, to past and prospective expenses both countrywide and those especially applicable to Illinois, and to all other factors, including judgment factors, deemed relevant within and outside Illinois. Consideration may also be given in the making and use of rates to dividends, savings or unabsorbed premium deposits allowed or returned by companies to their policyholders, members or subscribers. The systems of expense provisions included in the rates for use by any company or group of companies may differ from those of other companies or groups of companies to reflect the operating methods of any such company or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof.	Not applicable with this filing.
Minimum Premium Rules			
Insurers may group or classify risks for establishing rates and minimum premiums.	215 ILCS 5/155.18	Risks may be grouped by classifications for the establishment of rates and minimum premiums.	Not applicable with this filing.
"A" RATED RISKS			
Individual Risk Rating			
Risks may be rated on an individual basis as long as all provisions required in Section 155.18 are met.	215 ILCS 5/155.18	Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. Such standards may measure any difference among risks that have a probable effect upon losses or expenses. Such classifications or modifications of classifications of risks may be established based upon size, expense, management, individual experience, location or dispersion of hazard, or any other reasonable considerations, and shall apply to all risks under the same or substantially the same circumstances or conditions. The rate for an established classification should be related generally to the anticipated loss and expense factors or the class.	Not applicable with this filing.
RISK CLASSIFICATION			
Risks may be grouped by classifications.	215 ILCS 5/155.18	Risks may be grouped by classifications for the establishment of rates and minimum premiums.	Not applicable with this filing.
Rating decisions based solely on domestic violence.	215 ILCS 5/155.22b	No insurer may that issues a property and casualty policy may use the fact that an applicant or insured incurred bodily injury as a result of a battery committed against him/her by a spouse or person in the same household as a sole reason for a rating decision.	Not applicable with this filing. Domestic violence considerations are not part of our rating plan.
Unfair methods of	215 ILCS 5/424(3)	It is an unfair method of competition or unfair and	Not applicable with

competition or unfair or deceptive acts or practices defined.		deceptive act or practice if a company makes or permits any unfair discrimination between individuals or risks of the same class or of essentially the same hazard and expense element because of the race, color, religion, or national origin of such insurance risks or applicants.	this filing. Our rating plan does not unfairly discriminate as defined by statute.
Procedure as to unfair methods of competition or unfair or deceptive acts or practices not defined.	215 ILCS 5/429	Outlines the procedures the Director follows when he has reason to believe that a company is engaging in unfair methods of competition or unfair or deceptive acts or practices.	Not applicable.
Territorial Definitions			
Rate/rule manuals must contain correct and adequate definitions of Illinois territories.	215 ILCS 5/155.18	When an insurer's rate/rule program includes differing territories within the State of Illinois, rate/rule manuals must contain correct and adequate definitions of those territories, and that all references to the territories or definitions are accurate, so the Division does not need to request additional information.	Page IL-1 of the Illinois exception manual.
ACTUARIAL SUPPORT INFORMATION REQUIRED			
ACTUARIAL CERTIFICATION			
Actuarial certification must accompany all rate filings and all rule filings that affect rates.	215 ILCS 5/155.18 50 IL Adm. Code 929 Actuarial Certification Form	Every rate and/or rating rule filing must include a certification by an officer of the company and a qualified actuary that the company's rates and/or rules are based on sound actuarial principles and are not inconsistent with the company's experience. Insurers may use their own form or may use the sample form created by the Division.	Included with this filing.
ACTUARIAL OR STATISTICAL INFORMATION			
Director may request actuarial and statistical information.	215 ILCS 5/155.18 50 IL Adm. Code 929	The Director may require the filing of statistical data and any other pertinent information necessary to determine the manner of promulgation and the acceptability or unacceptability of a filing for rules, minimum premiums, rates, forms or any combination thereof. If the Director requests information or statistical data to determine the manner the insurer used to set the filed rates and/or to determine the reasonableness of those rates, as well as the manner of promulgation and the acceptability or unacceptability of a filing for rules, minimum premiums, or any combination thereof, the insurer shall provide such data or information within 14 calendar days of the Director's request.	Not applicable with this filing.
Explanatory Memorandum			
Insurers shall include actuarial explanatory memorandum with any	215 ILCS 5/155.18 50 IL Adm. Code	Insurers shall include actuarial explanatory memorandum with any rate filing, as well as any rule filing that affects the ultimate premium. The	Not applicable with this filing.

rate filing, as well as any rule filing that affects the ultimate premium.	929	explanatory memorandum shall contain, at minimum, the following information: • Explanation of ratemaking methodologies. • Explanations of specific changes included in the filing. • Narrative that will assist in understanding the filing.	
Summary of Effects Exhibit			
Insurers shall include an exhibit illustrating the effect of each change and calculation indicating how the final effect was derived.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include an exhibit illustrating the effect of each individual change being made in the filing (e.g. territorial base rates, classification factor changes, number of exposures affected by each change being made, etc.), and include a supporting calculation indicating how the final effect was derived.	Not applicable with this filing.
Actuarial Indication			
Insurers shall include actuarial support justifying the overall changes being made.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include actuarial support justifying the overall changes being made, including but not limited to: • Pure premiums (if used). • Earned premiums. • Incurred losses. • Loss development factors. • Trend factors. • On-Level factors. • Permissible loss ratios, etc.	Not applicable with this filing.
Loss Development Factors and Analysis			
Insurers shall include support for loss development factors and analysis.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include actuarial support for loss development factors and analysis, including but not limited to loss triangles and selected factors, as well as support for the selected factors.	Not applicable with this filing.
Ultimate Loss Selections			
Insurers shall include support for ultimate loss selections.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include support for ultimate loss selections, including an explanation of selected losses if results from various methods differ significantly.	Not applicable with this filing.
Trend Factors and Analysis			
Insurers shall include support for trend factors and analysis.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include support for trend factors and analysis, including loss and premium trend exhibits demonstrating the basis for the selections used.	Not applicable with this filing.
On-Level Factors and Analysis			
Insurers shall include support for on-level factors and analysis.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include support for on-level factors and analysis, including exhibits providing on-level factors and past rate changes included in calculations.	Not applicable with this filing.
Loss Adjustment Expenses			

Insurers shall include support for loss adjustment expenses.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include support for loss adjustment expenses, including exhibits providing documentation to support factors used for ALAE and ULAE. If ALAE is included in loss development analysis, no additional ALAE exhibit is required.	Not applicable with this filing.
Expense Exhibit			
Insurers shall include an expense exhibit. Insurers may use expense provisions that differ from those of other companies or groups of companies.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include an exhibit indicating all expenses used in the calculation of the permissible loss ratio, including explanations and support for selections. The systems of expense provisions included in the rates for use by any company or group of companies may differ from those of other companies or groups of companies to reflect the operating methods of any such company or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof.	Not applicable with this filing.
Investment Income Calculation			
Insurers shall include an exhibit for investment income calculation.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include an exhibit demonstrating the calculation for the investment income factor used in the indication.	Not applicable with this filing.
Profit and Contingencies Calculation			
Insurers shall include an exhibit for profit and contingencies load.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include an exhibit illustrating the derivation of any profit and contingencies load.	Not applicable with this filing.
Credibility Standard Used			
Insurers shall include the number of claims being used to calculate the credibility factor.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers should include the number of claims being used to calculate the credibility factor. If another method of calculating credibility is utilized, insurers should include a description of the method used.	Not applicable with this filing.
Other Actuarial Information Required			

Insurers must include the information described in this section.	215 ILCS 5/155.18
	
	50 IL Adm. Code 929
		Insurers shall also include the following information:
		
		• All actuarial support/justification for all rates being changed, including but not limited to changes in:
		
		  ○ Base rates;
		  ○ Territory definitions;
		  ○ Territory factor changes;
		  ○ Classification factor changes;
		  ○ Classification definition changes;
		  ○ Changes to schedule credits/debits, etc.
		
		• Exhibits containing current and proposed rates/factors for all rates and classification factors, etc. being changed.
			Not applicable with this filing.

		• Any exhibits necessary to support the filing that are not mentioned elsewhere in this checklist.	
Schedule Rating			
Insurers must include the described information described at right.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers should include appropriate actuarial justification when filing schedule rating plans and/or changes to schedule rating plans.	Not applicable with this filing.